
Delivery via email to: Threecbuckingbulls@yahoo.com

November 16, 2022

License Number: Rc4101
Survey Event ID: 2EBW11

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

Dear Ms. Cook:

Enclosed is the summary of deficiencies from the complaint investigation conducted at your Residential Care Facility on **November 1, 2022**.

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 60 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.

You must submit an acceptable plan of correction within ten business days of receipt of the deficiencies identified on the STATE FORM. Please submit your plan of correction under the second column on the STATE FORM. Address each deficiency, and include the month, day, and year of the expected completion date in the third column. Sign, date, and indicate your title in the appropriate blocks on page 1 of the form. Return the STATE FORM with your completed plan of correction by email to:

LTCEnforcement@health.ok.gov

Or send by mail to:

Long Term Care Enforcement Division
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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 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.

You will be notified you of any enforcement actions being taken. If you have questions or need assistance, please feel free to contact me at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT LICENSURE

Facility: 3C Old Fashioned Boarding Home
Address: 719 South Jim Thorpe BLVD
City, State, Zip: Prague OK 74864
Provider #: RC4101
Complaint #: OK00059669
Investigation Dates: 10/28/22 and 11/01/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility neglected to ensure staff was qualified/certified for assigned tasks resulting in harm to residents.	S
2. The facility failed to provide a safe environment that is free of hazards.	S
3. The facility failed to have an effective pest control program.	S

☐ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/28/2022 at 11:00 a.m.

A sample of eleven residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R510 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R361, and, R411 for details.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R345 and R351 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1, 2 and #3. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "Billie Seeman", written over a horizontal line.

Billie Seeman, RN, CHFS

Date report completed: 11/04/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 A complaint investigation (OK00059669) was conducted on 10/28/22 and 11/01/22. Listed below are abbreviations that will be used throughout this document. AOS - arrival on scene CPR - Cardiopulmonary Resuscitation DNR - Do Not Resuscitate EMS - Emergency Medical Services PT - patient TOD - time of death	R 000		
R 345 SS=E	310:680-5-7(l) RESIDENT ROOMS - MATTRESS/BED LINENS (l) Each resident's bed shall have a comfortable mattress and bed linens which are clean and in good condition. This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure pillows, bed linens, and mattresses were comfortable, clean, and in good repair for nine (#3, 4, 5, 6, 7, 8, 9, 10 and #11) of nine sampled residents. The owner identified 19 residents resided in the home. Findings: On 10/28/22 at 11:39 a.m., resident rooms were observed. All beds observed had black stains on the mattresses and box springs. Resident #3's bed was observed to have an	R 345		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 1 indentation in the mattress. Resident #4's mattress had black stains on the mattress. Resident #5's mattress was observed to have a brown sheet on the bed with a hole in the sheet. Resident #6's bed had a hole underneath of the mattress and had an indentation in the middle of the mattress. Resident #7's mattress had a hole on the underneath of the mattress. Resident #8's pillow was stained, flat, and had uneven stuffing. Resident #9's mattress had a dirty sheet on the bed. Resident #10's pillow was stained with uneven stuffing. Resident #11's pillow was stained, had holes, and uneven stuffing. On 11/01/22 at 11:12 a.m., the owner was asked what the black stains were on the mattresses. They stated it was from the bed bugs. The owner was asked about the condition of the resident's mattresses and pillows. The owner stated the mattresses needed to be replaced and they were in the process of ordering new mattresses. The owner was asked if they had a purchase order for the new mattresses. They stated no. On 11/01/22 at 1:31 p.m., Resident #5 was asked about their mattress. Resident #5 stated there was black stains on their mattress.	R 345		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 2 On 11/01/22 at 1:44 p.m., Resident #9 was asked about their mattress. Resident #9 stated they had black stains on their mattress. Resident #9 stated they would like to have a new pillow. On 11/01/22 at 1:49 p.m., Resident #10 stated their mattress was rough and they needed a new pillow. On 11/01/22 at 2:00 p.m., Resident #6 stated their mattress sagged a little and they needed a new mattress.	R 345		
R 351 SS=E	310:680-7-3 INSECT AND RODENT CONTROL Methods shall be employed to prevent the entrance and harborage of insects, spiders, and rodents. Homes shall be kept free of insects, and rodents. This Rule is not met as evidenced by: Based on record review, observation, and interview, the home failed to have an effective pest control program to prevent the harborage of bed bugs for six (#3, 5, 6, 8, 10, and 11) of nine sampled residents who were reviewed for bed bugs and failed to ensure insecticides were used according to manufacturer's instructions. The owner identified 19 residents resided in the home. Findings:	R 351		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 3 The owner stated they did not have a pest control policy. The pest control logs were reviewed and revealed the home had used a professional pest control service for treatment of bed bugs in 2018, 2019, 2020, 2021, and 2022. The last professional pest control service for bed bugs was on 04/12/22. On 10/28/22 at 11:27 a.m., the owner stated they had been trying to get rid of the bed bugs for a long time. The owner stated they were no longer using a professional pest control service because it was too expensive and they were not getting rid of the bed bugs. The owner stated they had tried three different pest control companies and they continued to have bed bugs. The owner stated they were now using bed bug bombs (foggers) and spray insecticides. The following bed bug insecticides were observed in the home: 1. Bed Bug and Flea Fogger, instructions read in parts, "...indoor residential use only... To delay insecticide resistance...consider...Avoiding the consecutive use of..Bedbug and Flea fogger...DO NOT use more than one fogger per room...BEFORE YOU FOG...Remove or cover dishes, utensils...Turn off ALL ignition sources such as pilot lights...Once canister has been activated place the canister on the chair small table or stand (that is covered by newspaper) in the center of the room to be treated..." 2. Tempo SC ultra, instructions read in parts, "...Reapply ever 7 to 10-days as needed...Restrictions...Do not apply to furniture or upholstery where prolonged contact by humans will occur..."	R 351		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 4 3. Premethren 13.3 % all purpose insecticide for ants, bed bugs, fleas, and ticks for indoor and outdoor use. On 10/28/22 at 11:35 a.m., resident rooms were observed with employee #6 for evidence of bed bugs. A live bed bug was observed on Resident #5's bed and two live bed bugs were observed on Resident #9's bed. Rooms #2, 3, 5, 6, 7, 8, and #9 were observed. Black stains were observed on the mattresses and box springs in all of the rooms. Live bed bugs, dead bed bugs, and/or evidence of bed bugs were observed in resident rooms. On 10/28/22 at 11:35 a.m., during observations of the resident rooms. Employee #6 was asked about the stains on the sides of the box springs. They stated some of the stains were from the bedbug spray. On 11/01/22 at 11:12 a.m., the owner stated they sprayed at least two times a week. The owner stated they sprayed the bottom of the box springs and around the edge of the rooms and doors. The owner stated the black areas on the mattresses and box springs were from bed bugs. The owner stated they did not document which rooms had been treated or the date the rooms were treated for bed bugs. The owner stated on 10/20/22 the residents were informed they were not allowed to attend the day treatment center until the bed bugs were under control.	R 351		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 5 On 11/01/22 at 12:18 p.m., the owner was asked based on the manufacturer's instructions how often the insecticide was supposed to be used. They stated they did not know. Employee #6 who was present during the interview with the owner and stated they used two bombs (foggers) per room and sprayed weekly or every other week. On 11/01/22 at 1:35 p.m., Resident #11 stated it had been eight days since they had seen a bed bug. Resident #11 stated they had been bitten by bed bugs in the past. On 11/01/22 at 1:39 p.m., Resident #3 stated they had seen bed bugs in the home. On 11/01/22 at 1:49 p.m., Resident #8 was asked if they had seen bed bugs. They stated yes. Resident #8 was asked if they had any skin irritations. They lifted up their shirt and red areas were noted on their chest and back. Resident #8 stated they had reported the bed bugs to the staff. On 11/01/22 at 1:54 p.m., employee #6 stated Resident #10 could not go in their room because it had been bombed with a bed bug fogger. Resident #10's door was open and two foggers were observed on the floor. Toothbrushes and cups were observed uncovered in the room. On 11/01/22 at 2:00 p.m., Resident #6 stated they had seen bed bugs a few nights ago. They stated they were at the end of the bed on the mattress.	R 351		
R 361 SS=F	310:680-7-5 (f) HOUSEKEEPING	R 361		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 361	Continued From page 6 (f) Home and surrounding areas shall be kept free from refuse, discarded furniture, and old newspaper. Combustibles such as cleaning rags and compounds must be kept in closed metal containers in areas away from residents' rooms. No items shall be stored in the hot water heater closet or furnace closet. This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure discarded furniture and refuse was not stored outside around the grounds of the home and failed to ensure items were not stored in the closet containing the hot water heater. The owner identified 19 residents resided in the home. Findings: 1. On 10/28/22 and 11/01/22 the following items were observed outside of the home: a. one mattress, one box spring, and a bed frame; b. three window screens; c. plastic trash bag filled with items; d. a glass globe ceiling light bulb cover filled with water; and, e. a green plastic tub turned upside down. On 11/01/22 at 11:12 a.m., the owner was shown the observations made of the items outside of the home. The owner stated they were waiting on the mattresses to be picked up. 2. On 10/28/22 at 11:20 a.m., the closet containing the hot water heater was observed with employee #6.	R 361		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 361	Continued From page 7 Shelves were observed across from the hot water heater. Canned foods were located on the shelves which included beans, whole peeled tomatoes, stewed tomatoes, peas, vegetables, and a sack of whole grain rye flour. A can of body CPVC cement (Solvent cement used to chemically fuse pipe and fittings together.) was stored on the top shelf above the food along with storage containers. A water hose, plastic sheeting, and an empty metal can, which employee #6 identified as a can used to put cigarette butts in, was located in the hot water heater closet along with the food items. On 10/28/22 at 11:20 a.m., employee #6 was asked about the food stored in the hot water heater closet and the can of body cement. They stated that was where they stored some of the food. Employee #6 stated the body cement can was empty.	R 361		
R 411 SS=F	310:680-9-1(j) FOOD SERVICE - Chapter 257 A residential care home shall be in compliance with Chapter 257 of this Title, regarding storage, preparation, and serving of food (including milk and ice). A residential care home may use residential equipment provided that the equipment must maintain hot and cold temperatures as required in OAC 310:257.	R 411		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 411	Continued From page 8 This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure they were in compliance with Chapter 257 related to food storage. 310:257-5-37(a)(1)(2)(3). Food Storage (a) Except as specified in (b) and (c) of this Section, food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (centimeters) (6 inches) above the floor..." Findings: On 10/28/22 at 11:05 a.m., a metal building next to the home was observed with employee #6. The following food items were stored on the carpeted floor: a. cardboard box containing four boxes of wheat thins. One box of wheat thins was open inside the cardboard box; b. two sacks of potatoes; c. six watermelons; d. a plastic sack containing cucumbers; e. cardboard boxes containing sacks of beans f. can foods of various sizes; and g. "Easy Sides" boxed food item Three containers of paint were stored on the floor near the food items. On 11/01/22 at 10:58 a.m., the owner/employee #3 was asked about the food stored in the floor in the metal building. The owner stated they used	R 411		

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: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 510	Continued From page 10 for two (#1 and #2) of seven employees who worked at the home and failed to ensure CPR was initiated for one (#1) of one sampled resident who became unresponsive. Resident #1 was not provided CPR until the emergency services arrived. Resident #1 was unable to be resuscitated and was pronounced dead. The owner identified 19 residents resided in the home and seven employees worked in the home. Findings: The home's undated CPR policy, read in parts, "Death Procedure 1. Check client 2. Start CPR 3. Have someone call 911 4. Call Police... 5. Call Administrator... Anytime a client says they are having chest pain call 911." 1. Employee files and time cards were reviewed and revealed the following employees had been working without current CPR certifications. Employee #1's date of hire was 06/04/20 and their CPR certification had expired on 03/2022. Employee #1 continued to work alone in the home without a current CPR certification after it had expired on 03/2022. Employee #1 was no longer employed at the home at the time of the survey. Employee #2's date of hire was 01/26/22 and they had received their CPR certification on 10/19/22. Employee #2 worked alone in the home for approximately nine months without CPR certification.	R 510		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 510	Continued From page 11 On 10/28/22 at 12:53 p.m., employee #2 stated they had been working at the home for almost a year. Employee #2 was asked if they were CPR certified. They stated they became CPR certified on 10/19/22. Employee #2 stated they had been working alone in the home. On 11/01/22 at 10:58 a.m., the owner/employee #3 stated they knew employee #2 was not CPR certified. The owner/employee #3 was asked why employee #2 was allowed to work without being CPR certified. They stated, "I do not know." 2. Resident #1 had diagnoses which included asthma, hypertension, and a history of bronchitis and pneumonia. Resident #1's admission form, dated 03/30/17, read in parts, "...I DO AUTHORIZE...TO TRANSPORT ME AND SECURE EMERGENCY TREATMENT..." No DNR form was found in Resident #1's clinical record. The home's "Confidential Critical Incident", report signed by employee #1, dated 07/09/22, read in parts, "...Incident Date 7/9/22 Time 7:42 pm...Incident...[Resident #1] fell roommate came told me Ran back with phone called...911...Action Taken Called 911 will follow up when we find out cause of death..." A "Prehospital Care Report", dated 07/09/22, read in parts, "...Patient History Information...Advance Directives None...Narrative...was dispatched emergency status...for a [age deleted] having a possible asthma attack...AOS to find several people standing outside of the pt room with his	R 510		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 510	Continued From page 12 door open. From ambulance EMS could see pt was laying prone [lying flat on stomach face down] on the ground inside [the resident's] room. Once entering the room, EMS turned pt to supine position [on back face up]...check for a pulse and breathing. Pt was found to be pulseless and apneic [not breathing] CPR was initiated...After approximately 30 minutes of CPR...advised to stop resuscitation efforts. TOD was called at 2018 [8:18 p.m.]...initial assessment...skin condition: cyanotic, warm and pale...Breathing: pt was apneic, no chest rise and fall...Circulation: cyanotic [Bluish or greyish discoloration of the skin due to deficient oxygenation of the blood.]...CPR First Initiated By First Responder (EMS)...date and time of initial CPR 2022-07-09 19:53:00 [7:53 p.m.]...Date/Time of Cardiac Arrest 2022-07-09 19:40:00 [7:40 p.m.]..." Review of time cards and personnel files revealed employee #1's CPR certification expired 03/2022 and no other employees were on site at the time of the incident on 07/09/22. On 10/28/22 at 1:15 p.m., employee #4 stated they arrived at the home on 07/09/22 and the ambulance personnel was at the home. Employee #4 stated they assisted the ambulance personnel with performing CPR for Resident #1. Employee #4 stated nobody was doing CPR when they arrived at the home. Employee #4 stated Employee #1 was working alone on 07/09/22. On 10/28/22 at 3:11 p.m., the owner/employee #3 stated employee #1 called them on 07/09/22 and when they arrived at the home the ambulance was already there. The owner/employee #3 stated the ambulance personnel started CPR on Resident #1 with the assistance of employee #4.	R 510		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 510	Continued From page 13 On 11/01/22 at 10:58 a.m., the owner/employee #3 was asked if employee #1 was the only staff member on duty on 07/09/22 at the time of the incident with Resident #1. They stated yes. The owner stated employee #1's CPR certification had expired. The owner was asked why employee #1 was not CPR certified. They stated employee #1 should have been CPR certified. They stated a former employee had been responsible for ensuring CPR certifications were current. The owner/employee #3 was asked when they became aware employee #1 was not CPR certified. They stated they were not aware until 10/28/22.	R 510		

Delivery via email to: Threecbuckingbulls@yahoo.com

December 2, 2022

License Number: RC4101
Survey Event ID: 2EBW11

Ms. Patsy Cook, Administrator
3C Old Fashioned Boarding Home
P.O. Box 48
Prague, OK 74864

Dear Ms. Cook:

On **November 1, 2022**, agents from our office completed a complaint 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:

- **Tag R345** does not address how they will correct the deficiency for the residents affected;
- **Tag R351** does not address the second part of the deficiency related to following manufacturer's instructions;
- **Tag R361** does not address the first part of the deficiency related to discard furniture and refuse stored on the grounds;
- **Tag R411** does not address the other food items stored on the floor;
- **Tag R510** does not address how they will ensure staff know when to start CPR, and how they will monitor to ensure CPR certifications are renewed when they expire and who would be responsible for monitoring CPR certifications.

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

Sincerely,

Katie Stagner

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 A complaint investigation (OK00059669) was conducted on 10/28/22 and 11/01/22. Listed below are abbreviations that will be used throughout this document. AOS - arrival on scene CPR - Cardiopulmonary Resuscitation DNR - Do Not Resuscitate EMS - Emergency Medical Services PT - patient TOD - time of death	R 000		
R 345 SS=E	310:680-5-7(I) RESIDENT ROOMS - MATTRESS/BED LINENS (I) Each resident's bed shall have a comfortable mattress and bed linens which are clean and in good condition. This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure pillows, bed linens, and mattresses were comfortable, clean, and in good repair for nine (#3, 4, 5, 6, 7, 8, 9, 10 and #11) of nine sampled residents. The owner identified 19 residents resided in the home. Findings: On 10/28/22 at 11:39 a.m., resident rooms were observed. All beds observed had black stains on the mattresses and box springs. Resident #3's bed was observed to have an	R 345	To correct this deficiency the housekeeping employee will check all mattress and linens and pillows every 2 weeks. If anything needs to be replaced it will be done.	1-2-23

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

Pat Cook

TITLE

Administrator

(X6) DATE

11-29-22

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 1 Indentation in the mattress. Resident #4's mattress had black stains on the mattress. Resident #5's mattress was observed to have a brown sheet on the bed with a hole in the sheet. Resident #6's bed had a hole underneath of the mattress and had an indentation in the middle of the mattress. Resident #7's mattress had a hole on the underneath of the mattress. Resident #8's pillow was stained, flat, and had uneven stuffing. Resident #9's mattress had a dirty sheet on the bed. Resident #10's pillow was stained with uneven stuffing. Resident #11's pillow was stained, had holes, and uneven stuffing. On 11/01/22 at 11:12 a.m., the owner was asked what the black stains were on the mattresses. They stated it was from the bed bugs. The owner was asked about the condition of the resident's mattresses and pillows. The owner stated the mattresses needed to be replaced and they were in the process of ordering new mattresses. The owner was asked if they had a purchase order for the new mattresses. They stated no. On 11/01/22 at 1:31 p.m., Resident #5 was asked about their mattress. Resident #5 stated there was black stains on their mattress.	R 345			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 2 On 11/01/22 at 1:44 p.m., Resident #9 was asked about their mattress. Resident #9 stated they had black stains on their mattress. Resident #9 stated they would like to have a new pillow. On 11/01/22 at 1:49 p.m., Resident #10 stated their mattress was rough and they needed a new pillow. On 11/01/22 at 2:00 p.m., Resident #6 stated their mattress sagged a little and they needed a new mattress.	R 345			
R 351 SS=E	310:680-7-3 INSECT AND RODENT CONTROL Methods shall be employed to prevent the entrance and harborage of insects, spiders, and rodents. Homes shall be kept free of insects, and rodents. This Rule is not met as evidenced by: Based on record review, observation, and interview, the home failed to have an effective pest control program to prevent the harborage of bed bugs for six (#3, 5, 6, 8, 10, and 11) of nine sampled residents who were reviewed for bed bugs and failed to ensure insecticides were used according to manufacturer's instructions. The owner identified 19 residents resided in the home. Findings:	R 351	To correct this deficiencies, we are using the same treatment but will log when it is used.		1-2-23

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 3 The owner stated they did not have a pest control policy. The pest control logs were reviewed and revealed the home had used a professional pest control service for treatment of bed bugs in 2018, 2019, 2020, 2021, and 2022. The last professional pest control service for bed bugs was on 04/12/22. On 10/28/22 at 11:27 a.m., the owner stated they had been trying to get rid of the bed bugs for a long time. The owner stated they were no longer using a professional pest control service because it was too expensive and they were not getting rid of the bed bugs. The owner stated they had tried three different pest control companies and they continued to have bed bugs. The owner stated they were now using bed bug bombs (foggers) and spray insecticides. The following bed bug insecticides were observed in the home: 1. Bed Bug and Flea Fogger, instructions read in parts, "...indoor residential use only... To delay insecticide resistance...consider... Avoiding the consecutive use of..Bedbug and Flea fogger...DO NOT use more than one fogger per room...BEFORE YOU FOG...Remove or cover dishes, utensils...Turn off ALL ignition sources such as pilot lights...Once canister has been activated place the canister on the chair small table or stand (that is covered by newspaper) in the center of the room to be treated..." 2. Tempo SC ultra, instructions read in parts, "...Reapply ever 7 to 10-days as needed...Restrictions...Do not apply to furniture or upholstery where prolonged contact by humans will occur..."	R 351			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 4 3. Premethren 13.3 % all purpose insecticide for ants, bed bugs, fleas, and ticks for indoor and outdoor use. On 10/28/22 at 11:35 a.m., resident rooms were observed with employee #6 for evidence of bed bugs. A live bed bug was observed on Resident #5's bed and two live bed bugs were observed on Resident #9's bed. Rooms #2, 3, 5, 6, 7, 8, and #9 were observed. Black stains were observed on the mattresses and box springs in all of the rooms. Live bed bugs, dead bed bugs, and/or evidence of bed bugs were observed in resident rooms. On 10/28/22 at 11:35 a.m., during observations of the resident rooms. Employee #6 was asked about the stains on the sides of the box springs. They stated some of the stains were from the bedbug spray. On 11/01/22 at 11:12 a.m., the owner stated they sprayed at least two times a week. The owner stated they sprayed the bottom of the box springs and around the edge of the rooms and doors. The owner stated the black areas on the mattresses and box springs were from bed bugs. The owner stated they did not document which rooms had been treated or the date the rooms were treated for bed bugs. The owner stated on 10/20/22 the residents were informed they were not allowed to attend the day treatment center until the bed bugs were under control.	R 351			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 5 On 11/01/22 at 12:18 p.m., the owner was asked based on the manufacturer's instructions how often the insecticide was supposed to be used. They stated they did not know. Employee #6 who was present during the interview with the owner and stated they used two bombs (foggers) per room and sprayed weekly or every other week. On 11/01/22 at 1:35 p.m., Resident #11 stated it had been eight days since they had seen a bed bug. Resident #11 stated they had been bitten by bed bugs in the past. On 11/01/22 at 1:39 p.m., Resident #3 stated they had seen bed bugs in the home. On 11/01/22 at 1:49 p.m., Resident #8 was asked if they had seen bed bugs. They stated yes. Resident #8 was asked if they had any skin irritations. They lifted up their shirt and red areas were noted on their chest and back. Resident #8 stated they had reported the bed bugs to the staff. On 11/01/22 at 1:54 p.m., employee #6 stated Resident #10 could not go in their room because it had been bombed with a bed bug fogger. Resident #10's door was open and two foggers were observed on the floor. Toothbrushes and cups were observed uncovered in the room. On 11/01/22 at 2:00 p.m., Resident #6 stated they had seen bed bugs a few nights ago. They stated they were at the end of the bed on the mattress.	R 351			
R 361 SS=F	310:680-7-5 (f) HOUSEKEEPING	R 361			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
---	---	--	--

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 361

Continued From page 6

(f) Home and surrounding areas shall be kept free from refuse, discarded furniture, and old newspaper.
Combustibles such as cleaning rags and compounds must be kept in closed metal containers in areas away from residents' rooms. No items shall be stored in the hot water heater closet or furnace closet.

This Rule is not met as evidenced by:
Based on observation and interview, the home failed to ensure discarded furniture and refuse was not stored outside around the grounds of the home and failed to ensure items were not stored in the closet containing the hot water heater.

The owner identified 19 residents resided in the home.

Findings:

1. On 10/28/22 and 11/01/22 the following items were observed outside of the home:

- a. one mattress, one box spring, and a bed frame;
- b. three window screens;
- c. plastic trash bag filled with items;
- d. a glass globe ceiling light bulb cover filled with water; and,
- e. a green plastic tub turned upside down.

On 11/01/22 at 11:12 a.m., the owner was shown the observations made of the items outside of the home. The owner stated they were waiting on the mattresses to be picked up.

2. On 10/28/22 at 11:20 a.m., the closet containing the hot water heater was observed with employee #6.

R 361

To correct this deficiency the outside pantry was cleaned. 1-2-23

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 361	Continued From page 7 Shelves were observed across from the hot water heater. Canned foods were located on the shelves which included beans, whole peeled tomatoes, stewed tomatoes, peas, vegetables, and a sack of whole grain rye flour. A can of body CPVC cement (Solvent cement used to chemically fuse pipe and fittings together.) was stored on the top shelf above the food along with storage containers. A water hose, plastic sheeting, and an empty metal can, which employee #6 identified as a can used to put cigarette butts in, was located in the hot water heater closet along with the food items. On 10/28/22 at 11:20 a.m., employee #6 was asked about the food stored in the hot water heater closet and the can of body cement. They stated that was where they stored some of the food. Employee #6 stated the body cement can was empty.	R 361			
R 411 SS=F	310:680-9-1(j) FOOD SERVICE - Chapter 257 A residential care home shall be in compliance with Chapter 257 of this Title, regarding storage, preparation, and serving of food (including milk and ice). A residential care home may use residential equipment provided that the equipment must maintain hot and cold temperatures as required in OAC 310:257.	R 411			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 411	Continued From page 8 This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure they were in compliance with Chapter 257 related to food storage. 310:257-5-37(a)(1)(2)(3). Food Storage (a) Except as specified in (b) and (c) of this Section, food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (centimeters) (6 inches) above the floor..." Findings: On 10/28/22 at 11:05 a.m., a metal building next to the home was observed with employee #6. The following food items were stored on the carpeted floor: a. cardboard box containing four boxes of wheat thins. One box of wheat thins was open inside the cardboard box; b. two sacks of potatoes; c. six watermelons; d. a plastic sack containing cucumbers; e. cardboard boxes containing sacks of beans f. can foods of various sizes; and g. "Easy Sides" boxed food item Three containers of paint were stored on the floor near the food items. On 11/01/22 at 10:58 a.m., the owner/employee #3 was asked about the food stored in the floor in the metal building. The owner stated they used	R 411	To correct this defici-deficiency the metal building has been cleaned. All the can food items 1-2-23 that was on the floor is no longer there.	

If continuation sheet 10 of 14

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 510	Continued From page 10 for two (#1 and #2) of seven employees who worked at the home and failed to ensure CPR was initiated for one (#1) of one sampled resident who became unresponsive. Resident #1 was not provided CPR until the emergency services arrived. Resident #1 was unable to be resuscitated and was pronounced dead. The owner identified 19 residents resided in the home and seven employees worked in the home. Findings: The home's undated CPR policy, read in parts, "Death Procedure 1. Check client 2. Start CPR 3. Have someone call 911 4. Call Police... 5. Call Administrator... Anytime a client says they are having chest pain call 911." 1. Employee files and time cards were reviewed and revealed the following employees had been working without current CPR certifications. Employee #1's date of hire was 06/04/20 and their CPR certification had expired on 03/2022. Employee #1 continued to work alone in the home without a current CPR certification after it had expired on 03/2022. Employee #1 was no longer employed at the home at the time of the survey. Employee #2's date of hire was 01/26/22 and they had received their CPR certification on 10/19/22. Employee #2 worked alone in the home for approximately nine months without CPR certification.	R 510			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
---	--	--	--

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 510

Continued From page 11

R 510

On 10/28/22 at 12:53 p.m., employee #2 stated they had been working at the home for almost a year. Employee #2 was asked if they were CPR certified. They stated they became CPR certified on 10/19/22. Employee #2 stated they had been working alone in the home.

On 11/01/22 at 10:58 a.m., the owner/employee #3 stated they knew employee #2 was not CPR certified. The owner/employee #3 was asked why employee #2 was allowed to work without being CPR certified. They stated, "I do not know."

2. Resident #1 had diagnoses which included asthma, hypertension, and a history of bronchitis and pneumonia.

Resident #1's admission form, dated 03/30/17, read in parts, "...I DO AUTHORIZE...TO TRANSPORT ME AND SECURE EMERGENCY TREATMENT..."

No DNR form was found in Resident #1's clinical record.

The home's "Confidential Critical Incident", report signed by employee #1, dated 07/09/22, read in parts, "...Incident Date 7/9/22 Time 7:42 pm...Incident...[Resident #1] fell roommate came told me Ran back with phone called...911...Action Taken Called 911 will follow up when we find out cause of death..."

A "Prehospital Care Report", dated 07/09/22, read in parts, "...Patient History Information...Advance Directives None...Narrative...was dispatched emergency status...for a [age deleted] having a possible asthma attack...AOS to find several people standing outside of the pt room with his

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/01/2022
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 510	Continued From page 12 door open. From ambulance EMS could see pt was laying prone [lying flat on stomach face down] on the ground inside [the resident's] room. Once entering the room, EMS turned pt to supine position [on back face up]...check for a pulse and breathing. Pt was found to be pulseless and apneic [not breathing] CPR was initiated...After approximately 30 minutes of CPR...advised to stop resuscitation efforts. TOD was called at 2018 [8:18 p.m.]...initial assessment...skin condition: cyanotic, warm and pale...Breathing: pt was apneic, no chest rise and fall...Circulation: cyanotic [Bluish or greyish discoloration of the skin due to deficient oxygenation of the blood.]...CPR First Initiated By First Responder (EMS)...date and time of initial CPR 2022-07-09 19:53:00 [7:53 p.m.]...Date/Time of Cardiac Arrest 2022-07-09 19:40:00 [7:40 p.m.]..." Review of time cards and personnel files revealed employee #1's CPR certification expired 03/2022 and no other employees were on site at the time of the incident on 07/09/22. On 10/28/22 at 1:15 p.m., employee #4 stated they arrived at the home on 07/09/22 and the ambulance personnel was at the home. Employee #4 stated they assisted the ambulance personnel with performing CPR for Resident #1. Employee #4 stated nobody was doing CPR when they arrived at the home. Employee #4 stated Employee #1 was working alone on 07/09/22. On 10/28/22 at 3:11 p.m., the owner/employee #3 stated employee #1 called them on 07/09/22 and when they arrived at the home the ambulance was already there. The owner/employee #3 stated the ambulance personnel started CPR on Resident #1 with the assistance of employee #4.	R 510			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
---	--	--	--

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 510	Continued From page 13 On 11/01/22 at 10:58 a.m., the owner/employee #3 was asked if employee #1 was the only staff member on duty on 07/09/22 at the time of the incident with Resident #1. They stated yes. The owner stated employee #1's CPR certification had expired. The owner was asked why employee #1 was not CPR certified. They stated employee #1 should have been CPR certified. They stated a former employee had been responsible for ensuring CPR certifications were current. The owner/employee #3 was asked when they became aware employee #1 was not CPR certified. They stated they were not aware until 10/28/22.	R 510		

Delivery via email to: Threecbuckingbulls@yahoo.com

December 12, 2022

License Number: RC4101
Survey Event ID: 2EBW11

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

Dear Ms. Cook:

On **November 1, 2022**, a complaint investigation was conducted at your Residential Care Facility. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **January 2, 2023**.

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,

Tempal Killman
Digitally signed by Tempal Killman
Date: 2022.12.12 09:41:30 -06'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

enc

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: RC4101	A. BUILDING: _____ B. WING: _____	C 11/01/2022	
NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 A complaint investigation (OK00059669) was conducted on 10/28/22 and 11/01/22. Listed below are abbreviations that will be used throughout this document. AOS - arrival on scene CPR - Cardiopulmonary Resuscitation DNR - Do Not Resuscitate EMS - Emergency Medical Services PT - patient TOD - time of death	R 000		
R 345 SS=E	310:680-5-7(I) RESIDENT ROOMS - MATTRESS/BED LINENS (I) Each resident's bed shall have a comfortable mattress and bed linens which are clean and in good condition. This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure pillows, bed linens, and mattresses were comfortable, clean, and in good repair for nine (#3, 4, 5, 6, 7, 8, 9, 10 and #11) of nine sampled residents. The owner identified 19 residents resided in the home. Findings: On 10/28/22 at 11:39 a.m., resident rooms were observed. All beds observed had black stains on the mattresses and box springs. Resident #3's bed was observed to have an	R 345	To correct this deficiency all mattress & bed linens & pillows will be replaced. To prevent this from happening again this is what will be done. To correct this deficiency the housekeeping employee will check all mattress and linens and pillows every 2 weeks. If anything needs to be replaced it will be done.	1-2-23

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

Pat Cook

TITLE
Administrator

(X6) DATE

11-29-22

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 1 indentation in the mattress. Resident #4's mattress had black stains on the mattress. Resident #5's mattress was observed to have a brown sheet on the bed with a hole in the sheet. Resident #6's bed had a hole underneath of the mattress and had an indentation in the middle of the mattress. Resident #7's mattress had a hole on the underneath of the mattress. Resident #8's pillow was stained, flat, and had uneven stuffing. Resident #9's mattress had a dirty sheet on the bed. Resident #10's pillow was stained with uneven stuffing. Resident #11's pillow was stained, had holes, and uneven stuffing. On 11/01/22 at 11:12 a.m., the owner was asked what the black stains were on the mattresses. They stated it was from the bed bugs. The owner was asked about the condition of the resident's mattresses and pillows. The owner stated the mattresses needed to be replaced and they were in the process of ordering new mattresses. The owner was asked if they had a purchase order for the new mattresses. They stated no. On 11/01/22 at 1:31 p.m., Resident #5 was asked about their mattress. Resident #5 stated there was black stains on their mattress.	R 345		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 2 On 11/01/22 at 1:44 p.m., Resident #9 was asked about their mattress. Resident #9 stated they had black stains on their mattress. Resident #9 stated they would like to have a new pillow. On 11/01/22 at 1:49 p.m., Resident #10 stated their mattress was rough and they needed a new pillow. On 11/01/22 at 2:00 p.m., Resident #6 stated their mattress sagged a little and they needed a new mattress.	R 345		
R 351 SS=E	310:680-7-3 INSECT AND RODENT CONTROL Methods shall be employed to prevent the entrance and harborage of insects, spiders, and rodents. Homes shall be kept free of insects, and rodents. This Rule is not met as evidenced by: Based on record review, observation, and interview, the home failed to have an effective pest control program to prevent the harborage of bed bugs for six (#3, 5, 6, 8, 10, and 11) of nine sampled residents who were reviewed for bed bugs and failed to ensure insecticides were used according to manufacturer's instructions. The owner identified 19 residents resided in the home. Findings:	R 351	To correct this deficiencies, we are using the same treatment but will log when it is used. We will use the product as directed on the labels.	1-2-23

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 3 The owner stated they did not have a pest control policy. The pest control logs were reviewed and revealed the home had used a professional pest control service for treatment of bed bugs in 2018, 2019, 2020, 2021, and 2022. The last professional pest control service for bed bugs was on 04/12/22. On 10/28/22 at 11:27 a.m., the owner stated they had been trying to get rid of the bed bugs for a long time. The owner stated they were no longer using a professional pest control service because it was too expensive and they were not getting rid of the bed bugs. The owner stated they had tried three different pest control companies and they continued to have bed bugs. The owner stated they were now using bed bug bombs (foggers) and spray insecticides. The following bed bug insecticides were observed in the home: 1. Bed Bug and Flea Fogger, instructions read in parts, "...indoor residential use only...To delay insecticide resistance...consider...Avoiding the consecutive use of..Bedbug and Flea fogger...DO NOT use more than one fogger per room...BEFORE YOU FOG...Remove or cover dishes, utensils...Turn off ALL ignition sources such as pilot lights...Once canister has been activated place the canister on the chair small table or stand (that is covered by newspaper) in the center of the room to be treated..." 2. Tempo SC ultra, instructions read in parts, "...Reapply ever 7 to 10-days as needed...Restrictions...Do not apply to furniture or upholstery where prolonged contact by humans will occur..."	R 351		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/01/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER 3C OLD FASHIONED BOARDING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 4 3. Premethren 13.3 % all purpose insecticide for ants, bed bugs, fleas, and ticks for indoor and outdoor use. On 10/28/22 at 11:35 a.m., resident rooms were observed with employee #6 for evidence of bed bugs. A live bed bug was observed on Resident #5's bed and two live bed bugs were observed on Resident #9's bed. Rooms #2, 3, 5, 6, 7, 8, and #9 were observed. Black stains were observed on the mattresses and box springs in all of the rooms. Live bed bugs, dead bed bugs, and/or evidence of bed bugs were observed in resident rooms. On 10/28/22 at 11:35 a.m., during observations of the resident rooms. Employee #6 was asked about the stains on the sides of the box springs. They stated some of the stains were from the bedbug spray. On 11/01/22 at 11:12 a.m., the owner stated they sprayed at least two times a week. The owner stated they sprayed the bottom of the box springs and around the edge of the rooms and doors. The owner stated the black areas on the mattresses and box springs were from bed bugs. The owner stated they did not document which rooms had been treated or the date the rooms were treated for bed bugs. The owner stated on 10/20/22 the residents were informed they were not allowed to attend the day treatment center until the bed bugs were under control.	R 351		