OKLAHOMA
State Department
of Health

**Delivery via email to:** spears.larry1@gmail.com; aberry@cotc.net

June 3, 2024

License Number: RC5401
Survey Event ID: **QKVS11**

Mr. Larry Spears, Jr., Administrator
Boley Residential Care Home #1
P.O. Box 295
Boley, OK 74829-0295

Dear Mr. Spears, Jr.:

Enclosed is the summary of deficiencies from the complaint investigation conducted at your Residential Care facility on **May 24, 2024**.

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

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

The criteria for an acceptable plan of correction are:

- A statement of exactly how the facility has or intends to correct each deficiency.
- The method of correction. This includes who is responsible for the correction.
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- A reasonable date of correction, which will normally be within 30 days of this notice.

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

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process.** Please retain a copy of this completed form for your files.

In the event that we find your Plan of Correction unacceptable, you will be notified of the reason(s) it is not acceptable and we will request another Plan of Correction. If your plan of correction is acceptable, there will be no acknowledgement. We will conduct a revisit in accordance with your stated correction dates. If you have any questions concerning this letter, please contact me at (405) 426-8200.

OKLAHOMA
State Department
of Health

In accordance with O.S. 63 830.1, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833-RC). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

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

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

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

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
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of Health

# INVESTIGATIVE REPORT

**Facility: Boley Residential Care Home #1**
**Address: 222 North Maple Street**
**City, State, Zip: Boley, Ok 74829**
**Provider #: RC5401**
**Complaint #: #OK00064801**
**Investigation Date(s): 05/22/24 through 05/24/24**

| ALLEGATION(S) |
| --- |
| The home failed to ensure residents were not physically, sexually or psychosocially abused. |

An unannounced on-site investigation was initiated 05/22/2024 at 1:35p.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

**A Summary of Complaint Investigation:**

A tour of the facility was conducted upon entrance. Resident's halls were observed for staff interaction.

Resident records were reviewed including resident council notes, trainings, in-house incident reports, state-reportable's. Policy and procedures were reviewed. Resident contracts and admission profiles were reviewed. Grievances and complaints were reviewed and nursing notes.

Residents were interviewed related to the provision of care from staff, safety concerns, abuse and filing complaints and grievances.

Staff were interviewed regarding reporting, abuse, safety and policy and procedures.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 05/24/2024

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 |
|---|---|---|---|
| | RC5401 | A. BUILDING: _____ B. WING _____ | C 05/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOLEY RESIDENTIAL CARE HOME #1 | 222 NORTH MAPLE STREET BOLEY, OK 74829 |

| (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<br><br>A compliant investigation (#OK00064801) was conducted on 05/22/24 through 05/24/24.<br><br>Facility Census: 29<br><br>Listed below are abbreviations that will be used throughout this document:<br><br>LPN-Licensed Practical Nurse<br>MAT-Medication Assisted Treatment | R 000 | | |
| R 234 SS=D | 310:680-3-7 (b)(7) RESIDENT RECORDS/RESIDENT'S ILLNESSES<br><br>(b) Every resident record shall be written in ink and include as a minimum, the following information:<br>(7) A record of the resident's illnesses, accidents, and unusual occurrence while a resident of the home.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation and interview, the facility failed ensure that incidents or occurrences were documented and reported for one (#3) of one sampled residents.<br><br>The LPN reported 29 consumers resided in the facility.<br><br>Findings:<br><br>Resident #3 had a diagnosis of schizophrenia.<br><br>On 05/23/24 at 4:50 p.m., Resident #3 reported to MAT#1 and MAT#2 that Resident #4 called their private parts a whore. | R 234 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | RC5401 | A. BUILDING: _____ B. WING _____ | C 05/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BOLEY RESIDENTIAL CARE HOME #1 | 222 NORTH MAPLE STREET BOLEY, OK 74829 |

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|---|---|---|---|---|
| R 234 | Continued From page 1<br><br>On 05/23/24 at 4:51 p.m., MAT#1 and MAT#2 reported that all incidents should be reported to the Nurse or Administrator.<br><br>On 05/24/24 at 11:20 a.m., LPN #1 reported that MAT #1 and MAT #2 should have reported and documented the incident.<br><br>On 05/24/24 at 11:21 a.m., LPN #1 reported the incident report book had no documentation of the incident or occurrence. | R 234 | | |

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**Delivery via email to:** spears.larry1@gmail.com; aberry@cotc.net

June 19, 2024

License Number: RC5401
Survey Event ID: **QKVS11**

Mr. Larry Spears, Jr., Administrator
Boley Residential Care Home #1
P.O. Box 295
Boley, OK 74829-0295

Dear Mr. Spears, Jr.:

On **May 24, 2024**, a complaint investigation 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 **July 1, 2024**.

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOLEY RESIDENTIAL CARE HOME #1 | 222 NORTH MAPLE STREET BOLEY, OK 74829 |

| (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 |
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| R 234 SS=D | 310:680-3-7 (b)(7) RESIDENT RECORDS/RESIDENT'S ILLNESSES<br><br>(b) Every resident record shall be written in ink and include as a minimum, the following information:<br>(7) A record of the resident's illnesses, accidents, and unusual occurrence while a resident of the home.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation and interview, the facility failed ensure that incidents or occurrences were documented and reported for one (#3) of one sampled residents.<br><br>The LPN reported 29 consumers resided in the facility.<br><br>Findings:<br><br>Resident #3 had a diagnosis of schizophrenia.<br><br>On 05/23/24 at 4:50 p.m., Resident #3 reported to MAT#1 and MAT#2 that Resident #4 called their private parts a whore. | R 234 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOLEY RESIDENTIAL CARE HOME #1 | 222 NORTH MAPLE STREET BOLEY, OK 74829 |

| (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 234 | Continued From page 1<br><br>On 05/23/24 at 4:51 p.m., MAT#1 and MAT #2 reported that all incidents should be reported to the Nurse or Administrator.<br><br>On 05/24/24 at 11:20 a.m., LPN #1 reported that MAT #1 and MAT #2 should have reported and documented the incident.<br><br>On 05/24/24 at 11:21 a.m., LPN #1 reported the incident report book had no documentation of the incident or occurrence. | R 234 | Administrator will review protocol/procedure for reporting and documenting resident's illnesses, accidents, and unusual occurrence in a mandatory staff meeting. The meeting is to ensure that all staff are aware of what is expected of them regarding reporting and documenting serious incidents as required.<br><br>The administrator will interview residents and staff monthly to ensure any resident illnesses, accidents, or unusual occurrences are reported and documented as required.<br><br>The administration, LPN, or designee will review the incident report book monthly to ensure all reported illnesses, accidents, or unusual occurrences are documented as required. | 06/21/2024<br><br>07/01/2024<br><br>07/01/2024 |

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**Delivery via email to:** dkelley1969@gmail.com; spears.larry1@gmail.com; aberry@cotc.net

July 25, 2024

License Number: RC5401
Survey Event ID: **QKVS12**

Mr. Larry Spears, Jr., Administrator
Boley Residential Care Home #1
222 North Maple Street
Boley, OK 74829

Dear Mr. Spears, Jr.:

On **July 24, 2024**, an offsite/paper revisit was conducted for 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 complaint survey on **May 24, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **July 1, 2024**.

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | RC5401 | A. BUILDING: _____ B. WING _____ | R-C 07/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BOLEY RESIDENTIAL CARE HOME #1 | 222 NORTH MAPLE STREET BOLEY, OK 74829 |

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|---|---|---|---|---|
| {R 000} | INITIAL COMMENTS<br><br>On 07/24/24, an offsite/revisit was conducted. The deficiencies from 05/24/24 were cleared. | {R 000} | | |

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