Oklahoma State Department of Health
Creating a State of Health

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November 6, 2019

License Number: Rc5402
Survey Event ID: 3XF011

Lavada Stacy Myers
The Rest Haven Management Company, Inc.
Four See 4c
368015 Old Highway 62
Boley, OK 74829

Dear Ms. Myers:

Enclosed is the summary of deficiencies from the survey conducted at your Residential Care Home on October 30, 2019. Please provide a plan of correction within 10 business days of receipt of this notice.

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 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 to:

Long Term Care Enforcement Division
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 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.

You will be notified separately by the Office of General Counsel regarding enforcement actions. If you have questions or need assistance, please feel free to contact me at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

Enclosure

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PRESS FIRMLY TO SEAL

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Oklahoma State Dept. of Health
Protective Health Services - LTC
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Oklahoma City OK 73117-1299

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TO:

Lavada Stacy Myers
The Rest Haven Management Compar
Four See 4c
368015 Old Highway 62
Boley, OK 74829-2914

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC5402	A. BUILDING _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEE 4C	368015 OLD HIGHWAY 62 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 A monitoring survey was conducted on 10/30/19. Current census was 5. The following deficient practices were cited.	R 000		
R 182 SS=F	63 O.S. 1-1950.1.B.1 CRIMINAL ARREST Except as otherwise provided by subsection C of this section, before any employer makes an offer to employ or to contract with a nurses aide or other person to provide nursing care, health-related services or supportive assistance to any individual except as provided by paragraph 4 of this subsection, the employer shall provide for a criminal arrest check to be made on the nurses aide or other person pursuant to the provisions of this section. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to complete a fingerprint-based Oklahoma National Background Check (OK Screen) for 2 (#1 and #2) of 2 recently hired employees. This failed practice had the widespread potential for more than minimal harm for all 5 residents. Findings: On 10/30/19 at 3:01 p.m., long term care	R 182		

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R 224	Continued From page 2 This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure an incident report was submitted to the Oklahoma State Department of Health (OSDH) no later than the next working day for 1 (#3) of 1 sampled resident who experienced psychological and physical abuse from an employee. This failed practice had the isolated potential for more than minimal harm. Findings: On 10/30/19 at 2:30 p.m., a tenant at a nearby independent care home reported his friend from the sister residential care home, resident #3, had been strangled and abused the previous week by the residential care home's co-owners' brother, driver/employee #3. The tenant then showed a picture of resident #3's neck with dark areas on it, that he stated were bruises. He stated he took the picture of resident #3's neck the day after the abuse incident happened. At 3:35 p.m., resident #3 was interviewed and stated, "(Name withheld-driver/employee #3) choked the Hell out of me. They are making me do things I don't want to do. Everybody saw it." He said he thought the incident happened four days previously, and the co-owner/chief financial officer (CFO) had told him to "Just drop it" and he was told "not to discuss it with anyone." Resident #3 stated he was scared and he thought he "was going to die if driver/employee #3 had not let his neck go." Resident #3 pointed to the right side of his neck and stated he had a bruise on his neck where he was choked. Resident #3 also stated driver/employee #3 had been back in the home three times, since the choking/strangulation incident had occurred. At 4:01 p.m., resident #2 stated he had witnessed	R 224		

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R 224	Continued From page 4 At 5:38 p.m., two county sheriff's deputies came and went in to the home to investigate the employee to resident abuse. Resident #3 was heard to tell the sheriff deputy "I thought I was going to die." At 6:10 p.m., a telephone message, with a picture, was received from the independent care home tenant, who sent the picture he had taken of resident #3 on his cellular phone on 10/23/19 at 10:17 a.m. The picture identified discolored marks on resident #3's neck. The picture was taken the day after the incident when resident #3 was choked/strangled by driver/employee #3.	R 224		
R 506 SS=F	310:680-11-1 (2)(A) STAFF QUALIFICATIONS - ADMINISTRATOR (2) Staff Qualifications. (A) Each residential care home shall have a person designated as "Administrator," who is at least 21 years old and has obtained a residential care administrator's certificate of training from an institute of higher learning whose program has been reviewed by the Department. This Rule is not met as evidenced by: Based on observation, interview and record review, the home failed to have a designated administrator. This failed practice has the widespread potential for more than minimal harm. Findings: On 10/30/19 at 3:35 p.m., there was no active administrator or person in the home to provide a plan of removal when an immediate jeopardy was identified.	R 506		

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R 506	Continued From page 6 charge of the home between 7:00 p.m. and 7:00 a.m. She also stated the co-owners' father sleeps in the home at times.	R 506		
R 817 SS=J	310:680-19-2 (a)(9) STATEMENT PROVISIONS (a) A statement of rights and responsibilities shall include but not be limited to the following: (9) Every resident shall be free from mental and physical abuse, and from physical and chemical restraints as provided by the program certification standards. This Rule is not met as evidenced by: On 10/30/19 at 3:35 p.m., an immediate jeopardy was identified related to the home's failure to protect a resident's health and safety from psychological and physical abuse from an employee, to include choking and strangulation. The immediate jeopardy situation was verified with the OSDH (Oklahoma State Department of Health). There was no active administrator available or person in the home able to provide a plan of removal. Based on observation and interview, it was determined the home failed to protect 1 (#3) of 1 sampled resident from psychological and physical abuse, to include choking and strangulation. This failed practice resulted in isolated actual psychological and physical harm. Findings: On 10/30/19 at 2:30 p.m., a tenant at a nearby independent care home reported his friend, resident #3, had been choked and strangled and	R 817		

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R 817	Continued From page 8 co-owner/CEO/previous administrator had reported the incident to OSDH. She was asked to provide a copy of the incident report and could not because she had to be emailed the incident report, and the printer was not working. At 4:21 p.m., the Manager of the Incident and Complaints division was contacted and stated OSDH was not in receipt of an incident report pertaining to resident abuse of resident #3 that occurred on 10/22/19. Driver/employee #2 stated he witnessed the incident where driver/employee #3 threw resident #3 on the ground, because he wanted the van keys. Driver/employee #2 stated driver/employee #3 still had access to all of the residents, and he told driver/employee #3 that he should have handled the incident totally different. He also stated the co-owner/CEO fired driver/employee #3, but he still came to the home. This individual also currently drives the tenants from the independent homes to the day treatment and also the residents of the licensed home. The CEO is also owner of the 2 independent homes. At 5:04 p.m., the Okfuskee County Sheriff's Department was called to report the assault on resident #3. At 5:15 p.m., the Okfuskee County Adult Protection Services was called to report the assault on resident #3. At 5:38 p.m., several county sheriff's deputies came to the home to investigate the employee to resident assault and allegation of abuse. Resident #3 was heard to tell the deputy, "I thought I was going to die."	R 817		

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