Oklahoma State Department of Health
Creating a State of Health

September 5, 2019

License Number: RC5402
Survey Event ID: Y3U611

Director
Four See 4c
368015 Old Highway 62
Boley, OK 74829

Dear Director:

Enclosed is a report of the complaint investigation conducted at your Residential Care facility on **August 20, 2019**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

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

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Four See 4C**
Address: **368015 Old Highway 62**
City, State, Zip: **Boley, OK, 74829**
Provider #: **RC 5402**
Complaint #: **OK00053892**
Investigation Date(s): **08/20/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to ensure medications and monies were sent with resident at the time of discharge.	US
2. The home failed to provide 3 meals a day.	US

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Tuesday, August 20, 2019 at 1:58 p.m.

A sample of 3 residents including any identified resident(s), 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to personal belongings sent with residents upon discharge was conducted.

An observation of the five residents that lived in the home was conducted and they had all of their belongings in their possession; with the exceptions of their medications, which was locked in a medication closet.

Residents stated the named resident had never lived in the residential care home, but he lived in town in one of the independent living homes. One of the resident stated he had a payee outside of the home. The other resident stated the co-owners were his payee and he received $25.00 to $50.00 per month for spending. Both

residents stated they received their medications daily. No administrator or employee was in the home to be interviewed regarding discharged residents and belongings.

At the time of investigation, there was no evidence of deficient practice related to retention of medication or money for a discharged resident.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to food/meals served in the home was conducted.

No meal was observed during survey, but food was observed in the refrigerator and upper freezer, chest freezer, on a kitchen table, and in the cabinets.

Residents stated they ate their meals at home and there was food for them to prepare. They were able to name the foods they had eaten for the past few meals. None of the residents stated they were hungry. One resident was observed eating a snack he had in his room.

At the time of investigation, there was no deficient practice related to lack of meals/food being served.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegations #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Marie Remer, RN, CHFS IV

Date report completed: 08/27/2019

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
	RC5402	A. BUILDING: _____ B. WING _____	08/20/2019

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 An abbreviated survey was conducted on 08/20/19 to investigate complaint #OK00053892. Current census was 5. No deficient practiced was cited.	R 000		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC5402	FOUR SEE 4C

Type of Survey (select all that apply)

3								

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. [illegible]25837	08/20/2019	08/20/2019	0.50	0.00	0.50	0.00	1.00	0.75
2. [illegible]36967	08/20/2019	08/20/2019	0.25	0.00	0.50	0.00	1.00	0.25
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

SEP 0 6 2019