OKLAHOMA
State Department
of Health

Delivery via email to: smanor.inc@yahoo.com

September 11, 2023

License Number: RC5512
Survey Event ID: C4J211

Ms. Tracy Estrada, Administrator
Shiloh Manor
8528 Southwest 74th Street
Oklahoma City, OK 73169

Dear Ms. Estrada:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey at your facility on **September 1, 2023**.

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

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

The criteria for an acceptable plan of correction are:

- 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.

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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.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Shiloh Manor**
Address: **8528 Southwest 74th Street**
City, State, Zip: **Oklahoma City, OK 73169**
Provider #: **RC5512**
Complaint #: **OK00060357**
Investigation Date(s): **08/31/23 and 09/01/23**

ALLEGATION(S)

The facility failed to ensure background checks were completed prior to employment
The facility failed to have and/or implement an effective pest control program.

An unannounced on-site investigation was initiated 08/31/2023 at 9:30 a.m.

A sample of nine 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:

Observations were made of staff interaction with residents, residents' interactions with each other, housekeeping and maintenance services. Observations were made of resident's rooms and the common area for pest and rodents.

Resident interviews were conducted regarding pest control staff treatment and clean environment.

Staff were interviewed regarding the facility hiring process, pest control and clean environment.

Facility records were reviewed to include employee files, background checks and pest control records.

The attached Statement of Deficiencies, Form 2567 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: 09/06/2023

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	RC5512	A. BUILDING: _____ B. WING _____	C 09/01/2023

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SHILOH MANOR	8528 SOUTHWEST 74TH STREET OKLAHOMA CITY, OK 73169

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R 000	INITIAL COMMENTS A relicensure survey was conducted from 08/31/23 through 09/01/23. A complaint investigation (#OK00060357) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CPR - cardiopulmonary resuscitation HSKP- housekeeper MAR- medication administration record MAT- medication administration technician mg- milligrams RN- registered nurse	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 mattresses were comfortable, clean, and in good repair in ten (#1, 2, 3, 4a, 4b, 6, 16, 17, 19, and #20) of twenty rooms observed. The facility census was 36. Findings: On 08/31/23 from 9:50 a.m. through 11:10 a.m., a tour of the facility was conducted. The following observations were made:	R 345		

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R 345	Continued From page 1 1- Room #16 had two beds with caved mattresses. 2- Room #19 bed to the right of the door mattress was caved in. 3- Room #17 bed to the right of the door mattress was caved in. 4- Room #20 had three beds two of the three had mattress that were caved in and worn down. 5- Room #2 bed located near the window was caved in. 6- Room #1 bed closest to the door was caved in. The resident, whose mattress was caved in, stated their mattress had been like that for a long time. 7- Room #3 was observed with four beds, the bed to the right of the door against the wall had a caved in mattress. 8- Room #4a, next to room #3, had two beds and the bed to the left of the door had a mattress that was caved in. 9- Room #4b, next to room #5, had two beds and the bed to the left of the door mattress was caved in. 10- Room #6 had a caved in mattress. On 08/31/23 at 10:29 a.m., Resident #3, who resided in room #4b next to #5, stated they needed to get a new mattress because it had been caved in a long time. On 08/31/23 at 10:36 a.m., Resident #9, who	R 345		

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R 345	Continued From page 2 resided in room #6, stated the mattress had been caved in a long time and needed replacement. 08/31/2023 at 1:05 p.m., Owner #1 stated they identified ten mattresses that needed replacement because they were caved in and they were looking for donations of new mattresses for them. The owner than stated it had been an on going issues with the mattresses being caved in. On 09/01/23 at 8:30 a.m., Resident #2, who resided in room #16, stated their mattress has been caved in for two years and they had been told they would be getting a new one. On 09/02/23 at 10:50 a.m., Resident #7, who resided in room #1, stated their mattress had been caved in and needed to be replaced for a long time.	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 observation, record review, and interview, the home failed to have an effective pest control program to prevent the harborage of bed bugs for six (#4a, 4b, 5, 16, 19 and #20) of 20 rooms observed for bed bugs.	R 351		

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R 351	Continued From page 3 The facility census was 36. Findings: An undated facility policy "Policy for Pest Control", read in part, "...It is the policy...to spray all rooms on a monthly basis....If a problem arises the admin. [administrator] will call to report the problem and schedule service to take care of it..." The pest control invoices, dated 10/19/22, 04/19/23 and 07/19/23 were reviewed. There was no documentation the pest control company had ever treated for bed bugs at the facility. On 08/31/23 from 9:50 a.m. through 11:10 a.m., a tour of the facility was conducted. The following observations were made: 1- Room #16 had two beds had bed bug tracks of black, red and brown stains on the mattress and mattress covers. 2- Room #19 bed to the right of the door had bed bug tracking of black, red and brown stains on the mattress and mattress cover. 3- Room #20 had two of the three beds had bed bug tracking of black, red and brown stains on the mattress and mattress cover. . 4- Room #4a, next to room three, to the left of the door had bed bug tracking of black, red and brown stains on the mattress and mattress cover. 5- Room #4b, next to room #5, had bed bug tracking of black, red and brown stains on the mattress and mattress cover. A live bed bug was observed in the crease of the mattress.	R 351		

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R 351	Continued From page 4 6- Room #5 was observed with bed bug tracking of black, red and brown stains on the mattress and mattress cover. On 08/31/23 at 10:29 a.m., Resident #3, who resided in room #4b, stated they have bed bugs and was observed with raised bumps on their arms. On 08/31/23 at 10:31 a.m., Resident #5, who resided in room #5, stated they had bed bugs and it had been on an on-going issue. Resident #5 further stated the facility can not get arid of the bed bugs. Resident #5 arms were observed with with raised bumps on their arms and Resident #5 stated they were bed bug bites. On 08/31/23 at 1:51 p.m., the administrator stated they have an on-going issue with the bed bugs because residents will bring them back from their day program. The administrator stated they do not use a professional pest control service for the bed bugs because Owner #2 can treat the facility.	R 351		
R 359 SS=E	310:680-7-5 (d) HOUSEKEEPING (d) Walls and ceilings shall be in good condition and shall be cleaned regularly. All homes shall have walls capable of being cleaned. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure shower room stalls and walls were maintained in a clean and sanitary condition for five of five shower rooms observed. The facility census was 36.	R 359		

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R 359	Continued From page 5 Findings: On 08/31/2023 from 9:50 a.m. through 11:10 a.m., a tour of the facility was conducted. The following observations were made: 1- Two shower rooms located in the halls where room 16, 17, 19 were located, had black mold like substances in the showers in the corners and a long the edges of the tub. 2- The shower room located near rooms 1 and 2 had chipped paint on the walls near the sink. The shower stall had bubble chipped walls. The corners and perimeter around the shower floor had a build up of thick black mold like substance. 3- The shower room located near the entrance to the facility had chipped paint on the walls near the sink and along the baseboards. The shower stall had a thick black mold like substance around the perimeter and dark brown stains on the floor. The shower caddy had a build of a black mold like substance. 4- The shower room close to room five and six was observed with chipped cracked paint on the wall. There was a black mold like substance on the wall above the shower stall. The shower stall corners and perimeter around the shower floor had a build up of a thick black mold like substance. On 08/31/23 at 1:05 p.m., Owner #1 stated they had plans to remodel all shower and bathrooms but have not been able to do so. When shown the condition of the rooms Owner #1 stated the rooms should not be in the condition they were in.	R 359		

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R 411	Continued From page 6	R 411		
R 411 SS=D	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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure hair nets were worn and food was prepared in a sanitary condition for one of one meal observation made. The facility census was 36. Findings: A facility undated policy, "Policy on Head and Beard Covers", read in part, "...all staff cooking or serving meals must and will wear head covers..." On 08/31/23 from 10:08 a.m. through 10:45 a.m., MAT #2 was observed in the kitchen preparing the noon meal for the residents. MAT #2 was observed without a hair net and wearing gloves. MAT #2 was observed touching the medication cart, surfaces where food was being prepared, the stove. The MAT then lifted the bologna to remove a red casing from the edges. MAT #2	R 411		

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R 411	Continued From page 7 was observed preparing bologna with same gloved hands without removing them and washing their hands. On 08/31/23 at 2:12 p.m., the administrator stated hair nets were to be worn while in the kitchen preparing food. The administrator stated staff are to wear gloves and change them between foods and touching surface and wash their hands before putting on new gloves. On 08/31/23 at 2:16 p.m., MAT #2 stated they were in a hurry and did not have a hair net on while preparing the meal. The MAT then stated they did not change gloves and wash their hands as they should have after touching the medication cart and other items in the kitchen and medication room.	R 411		
R 505 SS=E	310:680-11-1 (1)(D) SUFFICIENT NUMBER - RN (1) Sufficient number of persons. (D) All residential care homes shall have a signed, written agreement with a registered nurse to act as a consultant. Documentation of the use of the nurse consultant shall be maintained in the home. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure they had a written agreement with their current registered nurse acting as their	R 505		

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R 505	Continued From page 8 consultant. The facility census was 36. Findings: During the entrance conference to the facility the administrator identified RN #2 as their nurse who completed the quarterly assessments and reviews. A review of the blue binder with employee records and written agreements was conducted. The binder contained a written agreement dated 01/02/23 with RN #1. There was no documentation in the binder of a written agreement between RN #2 and the facility. The quarterly nursing reviews for Resident #1 through #9, for March and July 2023, contained the signature of RN #2 as the nurse completing the assessment. On 08/31/23 at 11:58 a.m., the administrator was asked for the written agreement with RN #2. The administrator looked through the blue binder and stated there was no written agreement in the binder and they would look for it in their office. On 08/31/23 at 12:14 p.m., the administrator stated they did not have a written agreement with RN #2. The administrator then stated RN #2 started in March of 2023.	R 505		
R 510 SS=E	310:680-11-1 (3)(A) STAFF TRAINING - FIRST AID/CPR (3) In order to ensure all homes maintain a level of competency necessary to meet the needs of	R 510		

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R 510	Continued From page 9 each individual served in the home, personnel must complete the following training requirements. (A) All employees shall be currently certified in first-aid and cardiopulmonary resuscitation (Red Cross training or equivalent). Proof of certification and training shall be kept on file in the home. First-Aid and CPR certificates shall be renewed annually, or as required to be kept current. This Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure staff were certified in first aid and cardiopulmonary resuscitation for seven (MAT #1, MAT #2, MAT #3, HSKP #1, HSKP #2, Owner #1, and Owner #2) of eight employee files reviewed for training. The facility census was 36. Findings: A review of the employee records for MAT #1, MAT #2, MAT #3, HSKP #1, HSKP #2, Owner #1,	R 510		

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R 510	Continued From page 10 and Owner #2 contained no documentation they were certified in first-aid and CPR. On 08/31/23 at 12:10 p.m., the administrator stated all first-aid and CPR certifications were located in the blue binder. The administrator stated they would look to see if there were any records of the certification for the employees. On 08/31/23 at 3:45 p.m., the administrator stated no other staff were certified except themselves. They further stated the problem was staff were required to pay for the course and that was not happening.	R 510		
R 633 SS=E	310:680-13-1 (2)(E) ADMINISTRATION OF MEDICATIONS (2) Administration of Medications. (E) All medications shall be administered according to label directions. This Rule is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure medications were administered as ordered for one (#9) of three sampled residents reviewed for medication destruction. Resident #9 had a current order for quetiapine (an antipsychotic medication) and had not been administered the medication for four days. The facility census was 36. Findings:	R 633		

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R 633	Continued From page 11 Resident #9's "Resident Information" sheet documented they had diagnosis of schizophrenia bipolar type. An "After Visit Summary", dated 07/26/23, documented Resident #9 was to stop taking quetiapine (Seroquel) 400 mg. Resident #9's MAR, dated July 2023, documented the medication was held due to order and not provided. Resident #9's MAR, dated August 2023, documented the medication was held due to order and not provided every day of the month. Resident #9's physician orders, documented the resident was to receive quetiapine 400 mg two tablets at bed time daily at 8:00 p.m. The orders were singed by the attending physician on 08/28/23. Resident #9 was not provided their quetiapine as ordered on 08/28/23, 08/29/23, 08/30/23 and 08/31/23. On 09/01/23 at 1:00 p.m., Resident #9's medications were observed on the medication cart. No quetiapine was located on the medication cart. MAT #3 was asked where the quetiapine was located for administration. The MAT stated Resident #9 had not had the medication since they went to the hospital in July. On 09/01/23 at 1:03 p.m., the administrator stated Resident #9 should be getting the medication. On 09/01/23 at 1:05 p.m., MAT #3 was asked	R 633		

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(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 633	Continued From page 12 about the signed physician orders dated 08/28/23. The MAT stated they were not aware of the orders because the administrator reviewed them and confirmed for a second time Resident #9 was not receiving the medication. On 09/01/23 at 1:15 p.m., the administrator stated the medication was stopped from 07/26/23 when back from the hospital and the doctor was in on 08/28/23 and he did not want the medication discontinued. The administrator further stated Resident #9 had missed four doses of the medication.	R 633		
R 701 SS=E	310:680-15-1 (a) RESIDENT'S CONTRACT (a) A written contract shall be executed between a resident or his/her guardian or responsible party, or if the resident is a minor, his parent, and a home or its agent within one hundred twenty (120) days from the time a resident is admitted to a home, or at the expiration of the period of previous contract, or when the source of payment for the resident's care changes from private to public funds or from public to private funds, or when the terms of the contract are changed. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete a written addendum or a new contract when monthly rent increased for eight (#1 through #8) of eight sampled residents. The facility census was 36. Findings:	R 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC5512	A. BUILDING: _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHILOH MANOR	8528 SOUTHWEST 74TH STREET OKLAHOMA CITY, OK 73169

(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 701	Continued From page 13 1. The face sheet for Resident #1 documented they had a monthly rent of $700. The admission contract, dated 01/01/22, documented the resident had a monthly rent of $730. Resident #1's fund ledger documented the monthly rent increased to $800 on 02/02/23. There was no contract addendum signed for the rent that increased on 02/02/23. On 09/01/23 at 7:52 a.m., Resident #1 stated they paid $800 a month in rent and the facility notified everyone in a large group meeting when it increased. Resident #1 stated they did not sign a new contract or agreement for the increase in rent. 2. The face sheet for Resident #2 documented they had a monthly rent of $700. The admission contract, dated 04/13/21, documented the resident had a monthly rent of $700. Resident #2's fund ledger documented the monthly rent increased to $800 on 02/02/23. There was no contract addendum signed for the rent that increased on 02/02/23. On 09/01/23 at 8:20 a.m., Resident #2 stated they paid $800 a month in rent and they did not sign a new contract or agreement for the increase in rent. Resident #2 further stated the facility told them of the increase in rent.	R 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC5512	A. BUILDING: _____ B. WING _____	C 09/01/2023

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R 701	Continued From page 14 3. Resident #3's admission contract, dated 04/26/22, documented the resident had a monthly rent of $730. Resident #3's fund ledger documented the monthly rent increased to $800 on 02/02/23. There was no contract addendum signed for the rent that increased on 02/02/23. On 09/01/23 at 8:50 a.m., Resident #3 stated they paid $800 a month in rent and they did not sign a new contract or agreement for the increase in rent. Resident #3 further stated the facility told them of the increase in rent in a group meeting. 4. Resident #4's admission contract, dated 01/0122, documented the resident had a monthly rent of $730. Resident #4's fund ledger documented the monthly rent increased to $800 on 02/02/23. There was no contract addendum signed for the rent that increased on 02/02/23. On 09/01/23 at 9:15 a.m., Resident #4 stated they paid $800 a month in rent and they did not sign a new contract or agreement for the increase in rent. Resident #4 further stated the facility told them of the increase in rent. 5. The face sheet for Resident #5 documented they had a monthly rent of $1100. Resident #5's admission contract, dated 01/01/23, documented the resident had a monthly rent of $1100. Resident #5's fund ledger documented the	R 701		

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R 701	Continued From page 15 monthly rent increased to $1600 on 04/03/23. There was no contract addendum signed for the rent that increased on 04/03/23. On 09/01/23 at 9:50 a.m., Resident #5 stated they paid monthly rent between $1,000 and $1,400 a month. Resident #5 stated their family member took care of the rent and they would be the ones to sign a new contract or agreement. On 09/01/23 at 10:12 a.m., the family member identified by Resident #5 stated they increased the rent to $1,600 and they did not sign a new contract or agreement. The family member then stated Resident #5 would sign the contract and agreement if there was a new a one. 6. The face sheet for Resident #6 documented they had a monthly rent of $870. Resident #6's admission contract, dated 01/01/23, documented the resident had a monthly rent of $980. Resident #6's fund ledger documented the monthly rent increased to $1050 on 02/03/23. There was no contract addendum signed for the rent that increased on 02/03/23. On 09/01/23 at 10:45 a.m., Resident #6 stated their rent increased to $1,050 six months ago and they were told in a group meeting of the increase. Resident #6 stated they had not signed a new contract with the increase. 7. The face sheet for Resident #7 documented they had a monthly rent of $700.	R 701		

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R 701	Continued From page 16 Resident #7's admission contract, dated 01/01/22, documented the resident had a monthly rent of $730. Resident #7's fund ledger documented the monthly rent increased to $800 on 02/06/23. There was no contract addendum signed for the rent that increased on 02/06/23. On 09/01/23 at 10:50 a.m., Resident #7 stated their rent was only $700 a month and stated they were not aware of any increases since they moved in. 8. The face sheet for Resident #8 documented they had a monthly rent of $700. Resident #8's admission contract, dated 01/01/22, documented the resident had a monthly rent of $730. Resident #8's fund ledger documented the monthly rent increased to $800 on 02/02/23. There was no contract addendum signed for the rent that increased on 02/02/23. 09/01/23 at 10:55 a.m., Resident #8 stated they were paying $800 a month in rent and he found out about the increase in the dining room in a big meeting. Resident #8 further stated the did not sign a new contract for the increase in rent. On 09/01/23 at 11:25 a.m., the administrator was asked about contract addendums when residents's monthly rent was increased. The administrator stated they gave a letter to all residents and would mail them to family. The administrator then stated they held a big group	R 701		

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R 701	Continued From page 17 meeting and told everyone about the increase. The administrator stated the letter would be located in the chart of the increases. The administrator was asked for the updated contract and agreements with the increases for Resident #1 through Resident #8. The administrator stated they would review the resident charts and contracts for the rent increase. On 09/01/23 at 11:55 a.m., the administrator stated that Resident #1 through Resident #8 had no updated contracts or agreements in writing and all contracts were not up to date.	R 701		

OKLAHOMA
State Department
of Health

Delivery via email to: smanor.inc@yahoo.com

October 2, 2023

License Number: RC5512
Survey Event ID: C4J211

Ms. Tracy Estrada, Administrator
Shiloh Manor
8528 Southwest 74th Street
Oklahoma City, OK 73169

Dear Ms. Estrada:

On **September 1, 2023**, agents from our office completed an 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:

- **R0633:** The plan of correction does not address how the MATs will know of newly signed physician's orders for medication.

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

Sincerely,

Lisa Calvin

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 000	INITIAL COMMENTS A relicensure survey was conducted from 08/31/23 through 09/01/23. A complaint investigation (#OK00060357) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CPR - cardiopulmonary resuscitation HSKP- housekeeper MAR- medication administration record MAT- medication administration technician mg- milligrams RN- registered nurse	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 mattresses were comfortable, clean, and in good repair in ten (#1, 2, 3, 4a, 4b, 6, 16, 17, 19, and #20) of twenty rooms observed. The facility census was 36. Findings: On 08/31/23 from 9:50 a.m. through 11:10 a.m., a tour of the facility was conducted. The following observations were made:	R 345		

Plan of correction

1. **R345-310:680-5-7(1) Residents rooms – mattress/bed liners**

   - The owner has been in contact with the community church to get help with the mattresses. With the help of our local church, All mattress cited will be replaced on 10/11/23.

   -To help aid this issue, the facility will begin going door to door in hopes of getting help from our community. The facility will be reaching out to the department of health for aid and resources. The facility will also visit local furniture stores in hopes of getting help with prices or possibly mattress donations.

2. **R351-310:680-7-3 Insect and rodent control**

   - The owner has stated she will seek a professional to spray specifically for bed bugs. This spray will be done by 10/11/23

   - To help aid this issue, the owner will be using a professional sprayer dedicated to bed bugs in between our normal in house sprays.

3. **R359-310:680-7-5 (D) House keeping**

   -As of 9/18/23 all bathrooms have been renovated and maintenance has done a deep clean of shower scum(is not mold).

   - To aid this issue the administer will discuss with nightshift employees about scrubbing the shower effectively to prevent soap scum. This will be discussed on 10/9/23 at the next staff meeting.

4. **R411-310:680-9-1(J) Food service – chapter 257**

   -On 9/2/23 The administrator talked to Mat #2 about the importance of wearing a hair net, changing gloves, washing hands and food prep.

   -To help prevent this issue the administrator will hold a staff meeting on 10/11/23 and discuss importance of wearing a hair net, changing gloves, washing hands and food prep.

5. **R505-310:680-11-1 (1)(D) Sufficient number -RN**

   -On 9/2/2023 the current RN singed the consulting agreement.

   -To help prevent this in the future, administrator will ensure agreements are signed.

6. **R510-310:680-11-1 (3)(A) Staff training- first aid and cpr**

   -As of 9/4/2023 MAT#1,#2,#3, and owner # 1 got cpr and first aid certified. House keeper #1 no longer works here. House keeper #2 who is new will be certified by 9/20/23. Owner#2 is not

building unless doing maintenance and does not work with residents and when owner # 2 is in building other certified staff members are present.

-To prevent this issue administrator will require certification before hiring.

7. **R633-310:680-13-1 (2)(E) Administration of medications**

- as of 9/6/2023 the psych physician decided to keep resident off Seroquel. A signed physician order was obtained and charted in resident #9 chart.

- to prevent is issue the administrator will work with physicians to ensure orders are correct.

8. **R701-310:680-15-1 (A) Residents Contract**

-On 10/11/2023 All residents face sheets, contracts and rent increase documents will be updated and signed by residents or guardians.

- To prevent this the administrator will ensure paperwork is always up to date.

Please let me know if you need any additional documentation or information to clear these deficiencies.

Sincerely,

Tracy Estrada- Administrator

OKLAHOMA
State Department
of Health

Delivery via email to: smanor.inc@yahoo.com

October 11, 2023

License Number: RC5512
Survey Event ID: C4J211

Ms. Tracy Estrada, Administrator
Shiloh Manor
8528 Southwest 74th Street
Oklahoma City, OK 73169

Dear Ms. Estrada:

On **September 1, 2023**, a Relicensure survey and a Complaint investigation were 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 **October 11, 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

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

enc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC5512	A. BUILDING: _____ B. WING _____	C 09/01/2023

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building unless doing maintenance and does not work with residents and when owner # 2 is in building other certified staff members are present.

-To prevent this issue administrator will require certification before hiring.

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- as of 9/6/2023 the psych physician decided to keep resident off Seroquel. A signed physician order was obtained and charted in resident #9 chart.

- to prevent is issue the administrator will work with physicians to ensure orders are correct.

- administrator will make mats aware of any newly signed physician orders.

8. **R701-310:680-15-1 (A) Residents Contract**

-On 10/11/2023 All residents face sheets, contracts and rent increase documents will be updated and signed by residents or guardians.

- To prevent this the administrator will ensure paperwork is always up to date.

Please let me know if you need any additional documentation or information to clear these deficiencies.

Sincerely,

Tracy Estrada- Administrator

OKLAHOMA
State Department
of Health

Delivery via email to: smanor.inc@yahoo.com

October 18, 2023

License Number: RC5512
Survey Event ID: C4J212

Ms. Tracy Estrada, Administrator
Shiloh Manor
8528 Southwest 74th Street
Oklahoma City, OK 73169

Dear Ms. Estrada:

On **October 13, 2023**, a revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Residential Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **September 1, 2023,** have now been corrected and your facility is in compliance with licensure standards effective **October 11, 2023.**

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
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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{R 000}	INITIAL COMMENTS A follow up was conducted on 10/13/23. All deficiencies from the 09/01/23 survey were cleared.	{R 000}		

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