



Oklahoma State Department of Health
Creating a State of Health

December 11, 2019

License Number: AL5502

Ms. Marsha Triplett, Administrator
Brookdale Bethany
4101 North Council Road
Bethany, OK 73008

RE: Survey Event ID: E6IE11

Dear Ms. Triplett:

On **October 9, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on October 9, 2019.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;

Board of Health

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- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. 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 the completed form for your files.

In accordance with O.S. 63-1-895, 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 833AL). 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 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,



Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE BETHANY

**4101 NORTH COUNCIL ROAD
BETHANY, OK 73008**

(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
N 000	Initial Comments A re-licensure survey was conducted on 10/07/19 through 10/09/17. Current census was 15. The following deficient practice was cited.	N 000		
N1105 SS=F	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure annual performance reviews were performed on 2 (#2 and #3) of 2 long term care aides (LTCA) who were employed longer than one year. This failed practice resulted in the widespread potential for more than minimal harm for all 15. Findings: On 10/07/19 at 12:13 p.m., a review of employee records revealed the following LTCA performance reviews had not been conducted since August	N1105		

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: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING. _____	(X3) DATE SURVEY COMPLETED 10/09/2019
NAME OF PROVIDER OR SUPPLIER BROOKDALE BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008		
(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
N1105	Continued From page 1 2018 for employee #2 who was hired 10/24/14; and employee #3 who was hired 08/24/18. At 3:00 p.m., the licensed practical nurse stated she had not known the LTCA performance reviews had to be conducted annually.	N1105		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to review an annual performance competency for 1 (#1) of 1 certified medication aide (CMA) who was employed longer than one year. This failed practice had the widespread potential for more than minimal harm for all 15 residents who received employee administered medications. Findings: On 10/07/19 at 12:13 p.m., a review of employee records revealed CMA/employee #1 was hired 08/11/17, and an annual review of her performance competencies had not been completed since August 2018. At 3:00 p.m., the licensed practical nurse stated she had not known CMA performance	N1442		

Oklahoma State Department of Health

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N1442	Continued From page 2 competencies had to be reviewed annually.	N1442		
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 10/07/19 through 10/09/19. Current census was 15. The following deficient practices were cited.	C 000		
C 701 SS=F	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure water temperatures did not exceed 115 degrees Fahrenheit (F) in the residents' rooms for 6 (#1 through #6) of 6 sampled residents. This deficient practice had the widespread potential for more than minimal harm. Findings: On 10/08/19 at 3:15 p.m., resident #2's bathroom hot water registered at 119.8 degrees F. She stated sometimes the water was too hot when she took a shower. At 3:32 p.m., the following hot water temperatures	C 701		

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C 701	Continued From page 3 were obtained: Resident #1 - 118.3 degrees F at the bathroom sink; Resident #3 - 119.1 degrees F at the bathroom sink; Resident #4 - 117.9 degrees F at the bathroom sink; Resident #5 - 118.6 degrees F at the bathroom sink; and Resident #6 - 118.3 degrees F at the bathroom sink. At 4:58 p.m., the administrator stated the anti-scald regulators were connected to the showers only and not on the sinks.	C 701		
C 711 SS=F	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on interview and record review, the center failed to ensure an annual fire marshal inspection had been completed. This failed practice resulted in the widespread potential for more than minimal harm for all 15 residents. Findings: On 10/08/19 at 10:32 a.m., the administrator	C 711		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER BROOKDALE BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008		
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C 711	Continued From page 4 provided a fire marshal's inspection dated 04/12/18. The administrator provided a sticky note which documented the following dates she had contacted the fire marshal's office on "08/06/19 - Will be here Sept - Oct. Running behind...09/09/19, 09/26/19, and 10/07/19.	C 711		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure medications were reviewed monthly by a registered nurse (RN) or pharmacist for 6 (#1 through #6) of 6 sampled residents. This failed practice had the widespread potential for more than minimal harm for all 15 residents who received employee administered medications. Findings: On 10/09/19 at 10:40 p.m., the sampled residents' charts were reviewed and there were no documentation of a monthly medication review conducted by the RN or pharmacist; nor was there a signature of the RN on any of the residents' medication administration records to indicate the medications had been reviewed. At 10:40 a.m., licensed practical nurse #1 stated in July the pharmacist consultant had suggested physician orders should have been sent to the physician's office for their signatures. She further	C 921		

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C 921	Continued From page 5 stated she had not observed any physician's orders or medication administration records signed by the RN since July.	C 921		
C6000 SS=F	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for	C6000		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5502	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 10/09/2019
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NAME OF PROVIDER OR SUPPLIER

BROOKDALE BETHANY

STREET ADDRESS, CITY, STATE, ZIP CODE

**4101 NORTH COUNCIL ROAD
BETHANY, OK 73008**

(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
C6000	Continued From page 6 employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the center failed to obtain a fingerprint-based national background check for 2 (licensed practical nurse #1 (LPN) and #4) of 2	C6000		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2019
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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
C6000	Continued From page 7 administrative position employees hired in the past year. This failed practice resulted in the widespread potential for more than minimal harm for all 15 residents. Findings: On 10/07/19 at 12:13 p.m., a review of employees' records revealed a fingerprint-based national background check had not been conducted on the following administrative employees: LPN #1 - hired 07/01/19; and Marketing manager/employee #4 - hired 05/20/19. At 3:21 p.m., the administrator stated the corporate office conducted background checks on the administrative employees when they were hired. She further stated she had not known a fingerprint-based national background check had not been included in the corporate office background check.	C6000		

STATE WORKLOAD REPORT

Provider/Supplier Number AL5502	Provider/Supplier Name BROOKDALE BETHANY
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Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

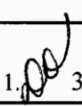
Extent of Survey (select all that apply)

A				
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- 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)
1.  35195	10/07/2019	10/09/2019	0.50	0.00	16.75	0.00	7.00	4.25
2.								
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

DEC 12 2019 



Oklahoma State Department of Health
Creating a State of Health

January 7, 2020

License Number: AL5502

Ms. Kristi Kelly-Bolner, Administrator
Homestead of Bethany, LLC/AKA: Brookdale Bethany
4101 North Council Road
Bethany, OK 73008

RE: Survey Event E6IE11

Dear Ms. Kelly-Bolner:

On October 9, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 19, 2020**.

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) 271-6868.

Sincerely,

Katie Stagner

for V. Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/ks

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
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R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

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Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF BETHANY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008		
(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
N 000	Initial Comments A re-licensure survey was conducted on 10/07/19 through 10/09/17. Current census was 15. The following deficient practice was cited.	N 000		
N1105 SS=F	310.677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure annual performance reviews were performed on 2 (#2 and #3) of 2 long term care aides (LTCA) who were employed longer than one year. This failed practice resulted in the widespread potential for more than minimal harm for all 15. Findings: On 10/07/19 at 12:13 p.m., a review of employee records revealed the following LTCA performance reviews had not been conducted since August	N1105		

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

TITLE

(X6) DATE



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/21/2019

Facility Name: Homestead of Bethany

License Number: AL- 5502

Survey Event ID: E6IE11

Date Survey Completed: 10/9/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1105

Based on: interview and record review, it was determined the center failed to ensure annual performance reviews were performed on 2 of the LTC aides who were employed longer than a year. This failed practice resulted in the widespread potential for more than minimal harm for all 15.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Will review skill checklist and certification for nursing staff the month before due. Will be keeping a binder on in-service, minutes and month due of skills/certification.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☒ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Date 12/23/2019

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date Enter a date of addendum **Submitted by** Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: [Surveyor](#)

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text](#)

Facility in Compliance by: [Click here to enter a date.](#)

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF BETHANY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008
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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
N1105	Continued From page 1 2018 for employee #2 who was hired 10/24/14; and employee #3 who was hired 08/24/18. At 3:00 p.m., the licensed practical nurse stated she had not known the LTCA performance reviews had to be conducted annually.	N1105		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to review an annual performance competency for 1 (#1) of 1 certified medication aide (CMA) who was employed longer than one year. This failed practice had the widespread potential for more than minimal harm for all 15 residents who received employee administered medications. Findings: On 10/07/19 at 12:13 p.m., a review of employee records revealed CMA/employee #1 was hired 08/11/17, and an annual review of her performance competencies had not been completed since August 2018. At 3:00 p.m., the licensed practical nurse stated	N1442		



Oklahoma State
Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/21/2019

Facility Name: Homestead of Bethany

License Number: AL- 5502

Survey Event ID: E6IE11

Date Survey Completed: 10/9/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1442

Based on: interview and record review, it was determined the center failed to ensure annual performance competency for 1 of 1 certified medication aide who was employed longer than one year. This failed practice had the widespread potential for more than minimal harm for all 15 residents who received employee administered medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Will review skill checklist and certification for nursing staff the month before due. Will be keeping a binder on in-service, minutes and month due of skills/certification.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Problem areas will be discussed during every morning meeting among staff. Staff will have to read in-service notes and sign off at which time they will have to demonstrate ability to perform such task.

1. Will investigate and the RCC will walk through skills checklist with each individual to make sure skills are through. Will also maintain a sign in sheet with minutes over topics covered and staff attendance.1.

1. Binder will be kept and reviewed at QAPI meeting every month prior to the expiration month.

1. Inservice will be held twice a month on payday with specific topics.

2 This will be monitored by the RCC and the Executive Director monthly.

3 Switch to state competency skills checklist for all nursing staff.

4. Will correlate the renewal of certification with renewal of skills checklist every year.

1/19/2020

Administrator's Signature

OAC 310:663-25-4(F)

Date 12/23/2019

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted

Addendum Date

Enter a date of addendum.

Submitted by

Enter name of person submitting addendum

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date](#) Surveyor: [Surveyor](#)

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text](#).

Facility in Compliance by: [Click here to enter a date](#).

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF BETHANY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008		
(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
N1442	Continued From page 2 she had not known CMA performance competencies had to be reviewed annually.	N1442		
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 10/07/19 through 10/09/19 Current census was 15 The following deficient practices were cited.	C 000		
C 701 SS=F	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure water temperatures did not exceed 115 degrees Fahrenheit (F) in the residents' rooms for 6 (#1 through #6) of 6 sampled residents. This deficient practice had the widespread potential for more than minimal harm. Findings: On 10/08/19 at 3:15 p.m., resident #2's bathroom hot water registered at 119.8 degrees F. She stated sometimes the water was too hot when she took a shower.	C 701		



Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/21/2019

Facility Name: Homestead of Bethany

License Number: AL- 5502

Survey Event ID: E6IE11

Date Survey Completed: 10/9/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C701

Based on: observation and interview it was determined the center failed to ensure water temperatures did not exceed 115 degrees Fahrenheit in the residents' room for 6 of 6 sampled residents. This failed practice resulted in the widespread potential for more than minimal harm for all 15.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Assisted living call in contractor to adjust and fix malfunction. Water temps will be checked once a week and log into "TELS".

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Date 12/23/2019

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum

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Facility in Compliance by: [Click here to enter a date](#)

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2019
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF BETHANY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008		
(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
C 701	Continued From page 3 At 3:32 p.m., the following hot water temperatures were obtained: Resident #1 - 118.3 degrees F at the bathroom sink; Resident #3 - 119.1 degrees F at the bathroom sink; Resident #4 - 117.9 degrees F at the bathroom sink; Resident #5 - 118.6 degrees F at the bathroom sink; and Resident #6 - 118.3 degrees F at the bathroom sink. At 4:58 p.m., the administrator stated the anti-scald regulators were connected to the showers only and not on the sinks.	C 701		
C 711 SS=F	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O S Sections 317 through 324.21. This Rule is not met as evidenced by. Based on interview and record review, the center failed to ensure an annual fire marshal inspection had been completed. This failed practice resulted in the widespread potential for more than minimal harm for all 15 residents. Findings	C 711		



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/21/2019

Facility Name: Homestead of Bethany

License Number: AL- 5502

Survey Event ID: E6IE11

Date Survey Completed: 10/9/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C711

Based on: interview and record review, the center failed to ensure an annual fire marshal inspection had been completed. This failed practice resulted in the widespread potential for more than minimal harm for all 15.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This is programed to show red in the TELS system 2 months in advance. Fire Marshall came and completed inspection.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Date 12/23/2019

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date

Enter a date of addendum

Submitted by

Enter name of person submitting addendum

Items Below Are For OSDH Use Only

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Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF BETHANY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008		
(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
C 711	Continued From page 4 On 10/08/19 at 10:32 a.m., the administrator provided a fire marshal's inspection dated 04/12/18. The administrator provided a sticky note which documented the following dates she had contacted the fire marshal's office on "08/06/19 - Will be here Sept - Oct. Running behind ..09/09/19, 09/26/19, and 10/07/19.	C 711		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure medications were reviewed monthly by a registered nurse (RN) or pharmacist for 6 (#1 through #6) of 6 sampled residents. This failed practice had the widespread potential for more than minimal harm for all 15 residents who received employee administered medications. Findings: On 10/09/19 at 10:40 p.m., the sampled residents' charts were reviewed and there were no documentation of a monthly medication review conducted by the RN or pharmacist; nor was there a signature of the RN on any of the residents' medication administration records to indicate the medications had been reviewed. At 10:40 a.m., licensed practical nurse #1 stated in July the pharmacist consultant had suggested physician orders should have been sent to the	C 921		



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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/21/2019

Facility Name: Homestead of Bethany

License Number: AL- 5502

Survey Event ID: E6IE11

Date Survey Completed: 10/9/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921

Based on: interview and record review , it was determined the center failed to ensure medications were reviewed by a RN or Pharmacist for 6 of the 6 sampled residents. This failed practice resulted in the widespread potential for more than minimal harm for all 15.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Assisted Living has an RN consultant 2 (8hours each day) times a month and a pharmacist that will be on-site 1(8hour day) time quarterly to review medications.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Date 12/23/2019

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Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

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Facility in Compliance by: [Click here to enter a date](#)

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2019
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF BETHANY, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008			
(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
C 921	Continued From page 5 physician's office for their signatures. She further stated she had not observed any physician's orders or medication administration records signed by the RN since July.	C 921			
C6000 SS=F	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking	C6000			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2019
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF BETHANY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008
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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
C6000	Continued From page 6 transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This STANDARD is not met as evidenced by. Based on interview and record review, it was determined the center failed to obtain a fingerprint-based national background check for 2	C6000		



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/21/2019

Facility Name: Homestead of Bethany

License Number: AL- 5502

Survey Event ID: E6IE11

Date Survey Completed: 10/9/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C6000

Based on: interview and record review, it was determined the center failed to obtain a fingerprint-based national background check for 2 of 2 administrative position employees hired in the past year. This failed practice resulted in the widespread potential for more than minimal harm for all 15.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Executive Director will maintain files on all employees hired to include copies of DL, certifications, background checks, fingerprints, etc.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted: Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted: Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted: Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted: Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted: Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Date 12/23/2019

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: Surveyor

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Facility in Compliance by: [Click here to enter a date.](#)



Oklahoma State Department of Health
Creating a State of Health

February 11, 2020

License Number: AL5502

Ms. Kristi Kelly-Bolner, Administrator
Brookdale Bethany
4101 North Council Road
Bethany, OK 73008

RE: Survey Event E6IE12

Dear Ms. Kelly-Bolner:

On **January 29, 2020**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 9, 2019**, have now been corrected effective **January 19, 2020**.

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis

for

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Board of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/29/2020
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF BETHANY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4101 NORTH COUNCIL ROAD BETHANY, OK 73008
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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
{N 000}	Initial Comments A follow-up survey was conducted on 01/27/2020 through 01/29/2020. Current census was 17. All deficient practices were cleared.	{N 000}		
{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 01/27/2020 through 01/29/2020. Current census was 17. All deficient practices were cleared.	{C 000}		

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT

 Provider/Supplier Number
 AL5502

 Provider/Supplier Name
 HOMESTEAD OF BETHANY,LLC

Type of Survey (select all that apply)

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

Extent of Survey (select all that apply)

A				
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- 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)
1. ^{0.01} 35195	01/27/2020	01/29/2020	0.50	0.00	3.75	0.00	2.25	0.50
2.								
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