Oklahoma State Department of Health
Creating a State of Health

February 12, 2020

License Number: AL5502

Ms. Kristi Kelly-Bolner, Administrator
Homestead Of Bethany,llc
4101 North Council Road
Bethany, OK 73008

RE: Survey Event ID: 3SYH11

Dear Ms. Kelly-Bolner:

On **January 29, 2020**, agents from our office concluded an initial/change of ownership 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 **January 29, 2020**.

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;

(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,

Katie Stagner

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5502	A. BUILDING _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF BETHANY,LLC	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 000	INITIAL COMMENTS An initial survey to a change of ownership due to operation entity changes was conducted on 01/27/2020 through 01/29/2020. Current census was 17. The following deficient practices were cited.	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to kitchen equipment and dish sanitation: 310:257-7-38. Warewashing machine, data plate operating specifications A warewashing machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine design and operating specifications including the: (1) Temperature required for washing, rinsing, and sanitizing; (2) Pressure required for fresh water sanitizing rinse unless the machine is designed to use only a pumped sanitizing rinse; and (3) Conveyor speed for conveyor machines or cycle time for stationary rack machines. 310:257-7-73. Mechanical warewashing equipment, hot water sanitation temperatures (a) Except as specified in (b) of this Section, in a	C 391		

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C 391	Continued From page 1 mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 90 degrees C (194 degrees F), or less than: (1) For a stationary rack, single temperature machine, 74 degrees C (165 degrees F); or (2) For all other machines, 82 degrees C (180 degrees F)... These failed practices had the widespread potential for more than minimal harm for all 17 residents who received their nutrition from the kitchen. Findings: 310:257-7-38. Warewashing machine, data plate operating specifications On 01/28/20 at 9:25 a.m., the data plate was not observed on the dishwasher. At 9:38 a.m., the maintenance person stood on top of a plastic bucket in an effort to locate a data plate for the dishwasher. The maintenance person and the dietary manager were unable to locate a data plate for the dishwasher. The maintenance person stated the data plate should have been visible. 310:257-7-73. Mechanical warewashing equipment, hot water sanitation temperatures On 01/29/20 at 3:00 p.m., the dishwasher temperature gauge during a wash cycle measured 150 degrees Fahrenheit (F) and the temperature gauge during a rinse cycle measured 158 degrees F. The dietary manager stated the dishwasher rinse temperature had not reached 180 degrees F for approximately six months. She further stated the company who provided maintenance of the dishwasher had advised them	C 391		

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C 391	Continued From page 2 to use a chemical sanitizer in the dishwasher. At 3:11 p.m., the maintenance person had located a data plate on the back of the dishwasher, against the wall. He stated the dishwasher was a high heat machine. He further stated the dishes are sanitized with heat and the dishwasher should not have chemicals for sanitation because heat killed the chemical sanitizer.	C 391		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure assessments were coordinated and signed by the registered nurse (RN) or the resident's personal physician for 2 (#1 and #6) of 8 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #1 On 01/29/20 at 1:03 p.m., a review of resident #1's records revealed a comprehensive assessment, dated 11/19/19, had not contained the signature of the RN or the resident's personal physician. RESIDENT #6 At 3:49 p.m., a review of resident #6's records revealed a comprehensive assessment, dated	C 542		

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C 542	Continued From page 3 12/03/19, had not contained the signature of the RN or the resident's personal physician. At 4:45 p.m., the licensed practical nurse (LPN) stated the previous owner's RN had not returned to the center to complete the residents' paper work. She further stated the new owner's RN would not sign the comprehensive assessments because the comprehensive assessments were dated prior to the new owner's take over of the center.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment form for 3 (#3, 4, and #7) of 8 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #3	C 543		

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C 543	Continued From page 4 On 01/29/20 at 1:29 p.m., a review of resident #3's records revealed a comprehensive assessment, dated 04/01/19, had not contained a signature of the resident or the resident's representative to indicate a personal interview had been conducted between them and the person who completed the assessment form. RESIDENT #4 At 1:43 p.m., a review of resident #4's records revealed a comprehensive assessment, dated 05/21/19, had not contained a signature of the resident or the resident's representative to indicate a personal interview had been conducted between them and the person who completed the assessment form. RESIDENT #7 At 2:40 p.m., a review of resident #7's records revealed a comprehensive assessment, dated 06/10/19, had not contained a signature of the resident or the resident's representative to indicate a personal interview had been conducted between them and the person who completed the assessment form. At 4:45 p.m., the licensed practical nurse (LPN) stated the comprehensive assessments were completed by the previous LPN and registered nurse. She did not know why the assessments were not signed by the resident or the resident's representative at the time the assessments were conducted.	C 543		
C1505	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care	C1505		

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C1505	Continued From page 5 Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure correct storage and maintenance of opened insulin pens for 2 (#1 and #5) of 2 sampled insulin dependent residents who had opened and undated insulin stored in the medication refrigerator. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #1	C1505		

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C1505	Continued From page 6 On 01/28/20 at 11:14 a.m., an inspection of the medication room refrigerator was conducted with the licensed practical nurse (LPN). Resident #1's opened and undated Basaglar Kwikpen insulin (used to treat high blood sugar) and an opened and undated HumaLOG Kwikpen insulin (used to treat high blood sugar) was observed. The LPN stated the insulin Kwikpens had not been dated with the date they were initially opened. She stated she thought the insulins expired 30 days after they had been opened. The LPN further stated she technically did not know if the insulin Kwikpens were safe to be administered because she did not know when they were opened. On 01/29/20 at 1:03 p.m., resident #1's records documented diagnoses which included long term use of insulin and type II diabetes mellitus with hyperglycemia. Physician orders for resident #1, dated 12/02/19, 12/08/19, and 01/07/20, documented Basaglar Kwikpen insulin to be administered two times a day and HumaLOG Kwikpen insulin to be administered as a sliding scale two times a day as needed. Resident #1's medication administration records (MAR), dated 12/01/19 through 12/31/19, documented Basaglar Kwikpen insulin was administered two times a day for 31 days and HumaLOG Kwikpen insulin as sliding scale was administered four times in 31 days. Resident #1's MAR, dated 01/01/20 through 01/31/20, documented Basaglar Kwikpen insulin was administered two times a day for 27 days and HumaLOG Kwikpen insulin as sliding scale was administered two times in 27 days.	C1505		

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C1505	Continued From page 7 On 01/29/20 at 9:40 a.m., the manufacturer's insert for resident #1's Basaglar KwikPen and HumaLOG KwikPen were reviewed with the LPN. The manufacturer's insert documented the insulin KwikPens were to be thrown away after 28 days. RESIDENT #5 On 01/28/20 at 11:14 a.m., resident #5's opened and undated Levemir FlexPen (used to treat high blood sugar) was observed in the medication refrigerator. The LPN stated the insulin FlexPen had not been dated with the date it was initially opened. She stated she thought insulin expired 30 days after it was opened. The LPN further stated she technically did not know if the insulin FlexPen was safe to be administered because she did not know when it was opened. On 01/29/20 at 3:27 p.m., resident #5's records documented diagnoses which included type II diabetes mellitus. Physician orders for resident #5, dated 12/11/19, documented Insulin Detemir Solution (Levemir) administered at bedtime and HumaLOG insulin administered as sliding scale two times a day as needed. Resident #5's December 2019 MAR documented Levemir was administered seven times and HumaLOG was administered one time, from 12/17/19 through 12/23/19, when she returned to the center. Home health communication notes for resident #5, dated 12/24/19 through 12/31/19, documented Levemir insulin was administered at bedtime each day.	C1505		

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C1505	Continued From page 8 Physician's orders for resident #5, dated 01/11/20, documented Levemir FlexPen administered in the morning starting 01/12/20. Resident #5's MAR, dated 01/01/20 through 01/29/20, documented Levemir FlexPen was administered at bedtime seven times, from 01/02/20 through 01/09/20, and 16 times, from 01/12/20 through 01/28/20, in the morning. On 01/29/20 at 9:50 a.m., the LPN stated resident #5's Levemir FlexPen came in a plastic baggie. No manufacturer's insert was in the plastic baggie with the insulin to determine the expiration date after it was opened.	C1505		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5502	HOMESTEAD OF BETHANY,LLC

Type of Survey (select all that apply)

1				

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

Extent of Survey (select all that apply)

A				

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	01/27/2020	01/29/2020	0.25	0.00	17.25	0.00	4.75	5.75
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**

Oklahoma State Department of Health
Creating a State of Health

March 5, 2020

License Number: AL5502

Ms. Kristi Kelly-Bolner, Administrator
Homestead Of Bethany,llc
4101 North Council Road
Bethany, OK 73008

RE: Survey Event 3SYH11

Dear Ms. Kelly-Bolner:

On January 29, 2020, 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 **April 16, 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,

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

SD/cn

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/19/2020** **Facility Name:** Homestead of Bethany **License Number:** AL- 5502 **Survey Event ID:** 3SYH11 **Date Survey Completed: 1/29/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: on observation and interview it was determined the center failed to ensure compliance with the Chapter 257 Food Service Establishment Regulations in regards to kitchen equipment and dish sanitation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: We will repair and /or replace dishwasher to make sure that it meets the Chapter 257 Food Service Establishment Regulations.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	1. Problem areas will be discussed during every morning meeting among staff. We will monitor water temps to make sure temperature is accurate to sanitation and label will be visible for easy access.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	1. Will investigate and Maintenace Director along with Dietary Manager will keep an upated temperature log and monitor the accuracy of the temperature while washing.
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?	1. Binder will be kept and reviewed at Safety Committee meeting every month of temperatures taken and discussed about being able to easily see label describing machine
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	1. Temperatures will be checked daily. 2. This will be monitored by the Maintenance Director and Dietary Manager. 3. Will physically make sure label is seen. 4. Will be discussed and reviewed monthly in Safety Committee Meeting.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/16/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Kristi Kelly-Bolner** OAC 310:663-25-4(F)	**Date 2/19/2020**

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/19/2020** **Facility Name:** Homestead of Bethany **License Number:** AL- 5502 **Survey Event ID:** 3SYH11 **Date Survey Completed: 1/29/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542	Based on: interview and record review, it was determined the center failed to ensure assessments were coordinated and signed by the registered nurse (RN) or the resident's personal physician for 2 (#1 and #6) of 8 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Will review and redo all state RN assessment and have new owner RN sign off on this. Will monitor that they are signed every month during QAPI meeting and daily discussion about new residents charts.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	1. Problem areas will be discussed during every morning meeting among staff. RCC and Executive Director will monitor and bring up in QAPI meeting. All assessments will be redone to be in accordance with new owner.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	1. All assessments will be redone to be in accordance with new owner. RCC will review monthly to make sure that they are signed by RN.
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?	1. Reviewed at QAPI meeting every month. All assessments will be reviewed monthly by RCC to make sure that they are up to date and signed by the RN.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	1. Every resident will have a new state RN assessment done in accordance with new ownership. 2. This will be monitored by the RCC and the Executive Director monthly. 3. QAPI Committee will discuss each month 4. RCC will maintain a spreadsheet and whiteboard showing when assessments are due.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/16/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Kristi Kelly-Bolner** OAC 310:663-25-4(F)	**Date 2/19/2020**

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/19/2020** **Facility Name:** Homestead of Bethany **License Number:** AL- 5502 **Survey Event ID:** 3SYH11 **Date Survey Completed: 1/29/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C543	Based on: interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment form for 3 (#3, 4 and #7) of 8 sampled residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Will review and redo all state RN assessment and have new owner RN sign off on this. Will monitor that they are signed every month during QAPI meeting and daily discussion about new residents charts. Will maintain a schedule of every other Tuesday to confer with resident or resident's representative about careplan.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	1. Problem areas will be discussed during every morning meeting among staff. RCC and Executive Director will monitor and bring up in QAPI meeting. All assessments will be redone to be in accordance with new owner.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	1. All assessments will be redone to be in accordance with new owner and state. 2. Routine schedule of every other Tuesday to confer with resident or resident's representative about careplan.
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?	1. Reviewed at QAPI meeting every month. All assessments will be reviewed monthly by RCC to make sure that they are signed and dated.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	1. Every resident will have a new state RN assessment done in accordance with new ownership. 2. This will be monitored by the RCC and the Executive Director monthly. 3. QAPI Committee will discuss each month 4. Will send out letters to notify resident and or resident's responsible party about time and date of careplan meeting.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/16/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Kristi Kelly-Bolner** OAC 310:663-25-4(F)	**Date 2/19/2020**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/19/2020** **Facility Name:** Homestead of Bethany **License Number:** AL- 5502 **Survey Event ID:** 3SHY11 **Date Survey Completed: 1/29/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: observation, interview and record review, it was determined the center failed to ensure correct storage and maintenance of opened insulin pens for 2 (#1 and #5) of 2 sampled insulin dependent residents who had opened and undated insulin stored in the medication refrigerator.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 change forms and include new forms for third party communication. Also have notified third party to inservice their staff on our new protocols and forms.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	1. Requested new insulin pens and documented date opened. Logged date, location of administration, how much and what FSBS is needs to be documented on new third party form.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	1. Will investigate and the RCC will follow up with third party on training before allowing third party to administer. RCC will instruct on new form and protocol.
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?	1. New third party form that will need specified documentation. 2. RCC and ACMA's will monitor insulin pens and forms.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	1. Changed third party form to include location of administration, how much was given, date of insulin given and opened and what the FSBS was. 2. Home Health will have their own log to sign off admistration. 3. Will call home health companies to make sure they have inserviced all of their staff to new protocol in building. 4. RCC will monitor forms monthly and ACMA's will monitor insulin weekly.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/16/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Kristi Kelly-Bolner** OAC 310:663-25-4(F)	**Date 2/19/2020**

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OKLAHOMA
State Department
of Health

Delivery via email to: alubbers@homesteadofbethany.com

May 6, 2021

License Number: AL5502

Ms. Amanda Lubbers, Administrator
Homestead Of Bethany,llc
4101 North Council Road
Bethany, OK 73008

RE: Survey Event 3SYH12

Dear Ms. Lubbers:

On **April 30, 2021,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your initial survey on **January 29, 2020,** have now been corrected effective **April 16, 2020.**

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

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2021.05.06 12:20:10 -05'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

LC/

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5502	A. BUILDING: _____ B. WING _____	R 04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF 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
{C 000}	INITIAL COMMENTS An offsite/paper revisit was completed on 04/30/21. Credible evidence of correction was submitted for all deficiencies.	{C 000}		