OKLAHOMA
State Department of Health

**Delivery via email to: mshrum@homesteadofdelcity.com**

February 9, 2024

License Number: AL5520

Ms. Mary Shrum, Administrator
Homestead Of Del City
5020 Southeast 44th Street
Oklahoma City, OK 73135

**Survey Event ID: F41B11**

Dear Ms. Shrum:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **February 2, 2024**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Homestead of Del City**
**Address:** **5020 Southeast 44th Street**
**City, State, Zip:** **Oklahoma City, OK, 73135**
**Provider #:** **AL5520**
**Complaint #:** **OK00062015**
**Investigation Date(s):** **02/01/24 through 02/02/24**

## ALLEGATION(S)

| |
|---|
| 1. The center failed to ensure residents were not involuntarily secluded and failed to ensure residents were not psychosocially abused. |
| 2. The center failed to provide a 30-day discharge notice to the resident/resident's responsible party. |
| 3. The center failed to provide a timely refund after a resident discharge. |
| 4. The center failed to provide discharge medication and medication administration records to the resident/resident's representative. |

enter text

An unannounced on-site investigation was initiated 05/01/2023 at 1:30 p.m.

A sample of two residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

**A Summary of Complaint Investigation:**

A tour of the facility was conducted upon entrance, at other various times throughout the survey. Observations were made of residents moving through the facility unrestrained.

Residents were interviewed regarding involuntary seclusion, concerns related to abuse, discharging from the facility processes and procedures.

Resident records reviewed included: progress and nurse’s notes, Resident assessments, incident reports, care plans, physician orders, abuse and discharge policies, and grievances.

Staff members were interviewed regarding the facility policies and procedures involuntary seclusion, abuse policies, abuse training, background checks, and discharge policies.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/02/2024

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 |
|---|---|---|---|
| | AL5520 | A. BUILDING: _____ B. WING _____ | C 02/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOMESTEAD OF DEL CITY | 5020 SOUTHEAST 44TH STREET OKLAHOMA CITY, OK 73135 |

| (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<br><br>A complaint investigation (#OK00062015) was conducted from 02/01/24 through 02/02/24. No deficiencies were cited.<br><br>Facility Census: 21 | C 000 | | |

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