Oklahoma State Department of Health
Creating a State of Health

February 18, 2020

License Number:

NH5520AL

Mr. James Duehning, Administrator
Baptist Village Of Oklahoma City
9700 Mashburn Boulevard
Oklahoma City, OK 73162

**RE: Survey Event ID: WG1P11**

Dear Mr. Duehning:

On **January 29, 2020**, 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 **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 <u>not</u> 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 |
|---|---|---|---|
| | NH5520AL | A BUILDING: _____ B WING _____ | 01/29/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BAPTIST VILLAGE OF OKLAHOMA CITY | 9700 MASHBURN BOULEVARD OKLAHOMA CITY, OK 73162 |

| (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<br><br>A re-licensure survey was completed on 01/27/20 to 01/29/20. Census was 35. Deficient practice was cited as follows. | N 000 | | |
| N1442 SS=E | 310:677-13-7 (c) Skills And Functions<br><br>(c) Skills review.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review it was determined the center failed to ensure validation of certified medication aide skills for 1 (#6) of 1 CMA (certified medication aide) prior to medication administration. This failed practice had the potential for more than minimal harm at a pattern. Findings:<br><br>On 01/28/2020 at 3:25 p.m., LPN (licensed practical nurse) #1 was asked if CMA #6, hired on 01/06/2020, had received verification of skills for medication administration from a licensed nurse prior to her starting on the cart. She stated no. LPN #1 provided a medication competency form for CMA #6 dated 11/25/2020 that was signed by RN (registered nurse) #1. LPN #1 was asked if RN #1 who signed the form had watched CMA #6 complete her competency skills. LPN #1 stated no, and that she had not dated the form correctly. | N1442 | | |

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| C 000 | INITIAL COMMENTS<br><br>A re-licensure survey was completed on 01/27/20 to 01/29/20. Census was 35. Deficient practice was cited as follows. | C 000 | | |
| C 954 SS=E | 310:663-9-5(d) STAFF QUALIFICATIONS<br><br>(d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review it was determined the center failed to ensure 6 ( #1, 2, 3, 4, 5, and #6) of 6 direct care staff had evidence of first aid training prior to the start of the survey on 01/27/2020. In addition the center failed to ensure 1 (#6) of 1 direct care staff had completed training in CPR (cardiopulmonary resuscitation). This deficient practice had the potential for more than minimal harm at a pattern. Findings:<br><br>On 01/27/2020 at 3:30 p.m., missing documentation for CPR and first aid for staffing was requested from LPN (licensed practical nurse) #1.<br><br>On 01/28/2020 at 3:25 p.m., LPN #1 was asked to look at the date on the CPR and first aid training test that was provided for employee #6. The form was dated 11/25/2020. The LPN stated she dated the form wrong, that CMA #6 had taken the CPR/first aid test the night before, on 01/27/2020. CPR and first aid tests for employees | C 954 | | |

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| C 954 | Continued From page 2<br>#1, #2, #3, #4, and #5 were provided with documentation signed and dated on 01/27/2020.<br><br>Employee #1 date of hire 07/31/2013,<br>Employee #2 date of hire 11/25/2014,<br>Employee #3 date of hire 09/01/2017,<br>Employee #4 date of hire 09/19/2018,<br>Employee #5 date of hire 03/14/2019; and<br>Employee #6 date of hire 01/06/2020. | C 954 | | |

FORM APPROVED

# *STATE WORKLOAD REPORT*

| Provider/Supplier Number | Provider/Supplier Name |
|---|---|
| NH5520AL | BAPTIST VILLAGE OF OKLAHOMA CITY |

Type of Survey (select all that apply)

[2]

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) |
|---|---|---|---|---|---|---|---|---|
| Team Leader ID | | | | | | | | |
| 1. 30875 | 01/27/2020 | 01/29/2020 | 0.50 | 0.00 | 16.25 | 0.00 | 5.00 | 0.50 |
| 2. 41872 | 01/27/2020 | 01/29/2020 | 0.50 | 0.00 | 16.25 | 0.00 | 6.00 | 2.50 |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |
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| 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 Yes

FEB 19 2020

OKLAHOMA
State Department
of Health

Delivery via email to: jduehning@okc.baptistvillage.org

November 12, 2020

License Number: NH5520AL

Mr. James Duehning, Administrator
Baptist Village Of Oklahoma City
9700 Mashburn Boulevard
Oklahoma City, OK 73162

**RE: Survey Event WG1P12**

Dear Mr. Duehning:

On **November 9, 2020,** an offsite/paper revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 29, 2020,** have now been corrected effective **March 13, 2020.**

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

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2020.11.12 13:06:37 -06'00'

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

Oklahoma State Department of Health

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|---|---|---|---|---|
| {C 000} | INITIAL COMMENTS<br><br>An Offsite/Paper Revisit was completed on 10/22/20. Credible evidence of correction was submitted for all deficiencies. | {C 000} | | |

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

Oklahoma State Department of Health

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|---|---|---|---|---|
| {N 000} | Initial Comments<br><br>An Offsite/Paper Revisit was completed on 11/09/20. Credible evidence of correction was submitted for all deficiencies. | {N 000} | | |

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