OKLAHOMA
State Department
of Health

Delivery via email to: rstringer@homesteadofkingfisher.com; tjackson@midwest-health.com

May 16, 2023

License Number: AL3701

Mr. Ronnie Stringer, Administrator
Homestead Of Kingfisher
1604 South 13th Street
Kingfisher, OK 73750

RE: Survey Event ID: R9Y411

Dear Mr. Stringer:

Enclosed is a report of the inspection and complaint investigation conducted at your Assisted Living Center on **May 11, 2023.** No deficiencies were cited. Oklahoma Statutes 63-1-1910 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.

Sincerely,

Lisa Calvin

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

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INVESTIGATIVE REPORT

Facility: **Homestead of Kingfisher**
Address: **1604 South 13th Street**
City, State, Zip: **Kingfisher, OK, 73750**
Provider #: **AL3701**
Complaint #: **OK00060279**
Investigation Dates: **05/10/23 and 05/11/23**

ALLEGATION

1. The facility failed to have an active and available administrator.

An unannounced on-site investigation was initiated 05/10/2023 at 12:39 p.m.

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

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 and at various times throughout the survey.

The Administrator was present at the facility at the time of entrance for survey and observed throughout the survey to interact with both staff and residents.

Residents interviewed regarding administrator availability and any issues or concerns with the facility.

Staff interviewed regarding administrator employment dates.

Deficient practice was not cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Tamara Thompson LPN CHFS

Date report completed: 05/12/2023

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
	AL3701	A. BUILDING: _____ B. WING _____	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF KINGFISHER	1604 SOUTH 13TH STREET KINGFISHER, OK 73750

(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 A relicensure survey was conducted from 05/10/23 through 05/11/23. A complaint investigation (#OK00060279) was conducted in conjunction with the survey. No deficiencies were cited.	C 000		

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