Oklahoma State Department of Health
Creating a State of Health

December 23, 2019

License Number: RC1802
Survey Event ID: PZW411

Mr. Randy McKinney, Director
Golden Life Residential Care
P.O. Box 180
Bluejacket, OK 74333

Dear Mr. McKinney:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey at your facility on **December 5, 2019**.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the space provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

(1) A statement of exactly how the facility has or intends to correct each deficiency.

(2) The method of correction. This includes who is responsible for the correction.

(3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

(4) A reasonable date of correction, which will normally be within 30 days of this notice.

NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **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 this completed form for your files.

In the event that we find your Plan of Correction unacceptable, you will be notified of the reason(s) it is not acceptable and we will request another Plan of Correction. If your plan of correction is acceptable, there will be no acknowledgement. We will conduct a revisit in accordance with your stated correction dates. If you have any questions concerning this letter, please contact me at (405) 271-6868.

In accordance with O.S. 63 830.1, 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 833-RC). 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 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 calendar days from receipt of the State Form deficiency statement. 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.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

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
	RC1802	A. BUILDING: _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIFE RESIDENTIAL	408 NORTH EAST CENTER BLUEJACKET, OK 74333

(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
R 000	INITIAL COMMENTS A re-licensure survey was conducted on 12/04/19 and 12/05/19. The census was 50. The following deficient practice was cited.	R 000		
R 182 SS=F	63 O.S. 1-1950.1.B.1 CRIMINAL ARREST Except as otherwise provided by subsection C of this section, before any employer makes an offer to employ or to contract with a nurses aide or other person to provide nursing care, health-related services or supportive assistance to any individual except as provided by paragraph 4 of this subsection, the employer shall provide for a criminal arrest check to be made on the nurses aide or other person pursuant to the provisions of this section. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to complete a fingerprint-based Oklahoma National Background Check for 4 (#2, 3, 4 and #5) of 4 recently hired employees. This failed practice	R 182		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC1802	A. BUILDING: _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIFE RESIDENTIAL	408 NORTH EAST CENTER BLUEJACKET, OK 74333

(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
R 182	Continued From page 1 had the widespread potential for more than minimal harm for all 50 residents. Findings: On 12/05/19 at 10:30 a.m., the administrative assistant was asked for a list of recently hired employees and if the home had obtained the required fingerprint-based Oklahoma National Background Check (OK Screen) for those employees. She stated she had not completed the OK Screen background checks the state required due to the company they had used was no longer able to provide service to the home. The employees who did not have an OK Screen background check completed were: Employee #2 Cook - hire date 9/12/19, Employee #3 medication administration technician/MAT - hire date 4/21/19, Employee #4 Cook - hire date 4/21/19; and Employee #5 night staff - hire date 4/21/19.	R 182		
R 310 SS=F	310:680-5-1 (10) GENERAL CRITERIA - SAFETY HAZARDS Residential care homes must meet or exceed the following requirements: (10) Each residential care home shall be free from safety hazards. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to be free from safety hazards of 2 broken windows with glass hanging	R 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC1802	A. BUILDING: _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIFE RESIDENTIAL	408 NORTH EAST CENTER BLUEJACKET, OK 74333

(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
R 310	Continued From page 2 loose. This failed practice had the widespread potential of more than minimal harm for all 50 residents. Findings: On 12/05/19 at 11:50 a.m., a tour outside the home was conducted with the assistance of the administrator. Two separate windows one at each end of the home had a cracked/broken glass on the outside pane (double pane windows). The administrator stated he was aware of 1 broken window.	R 310		
R 322 SS=F	310:680-5-5 FIRE SAFETY Each residential care home shall provide documentation that the State Fire Marshal or the State Fire Marshal's representative has inspected and approved the home prior to issuance of an initial license. Each residential care home with more than six beds shall provide documentation of annual inspection and approval prior to issuance of a license renewal. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to provide documentation the State Fire Marshal or their representative completed an annual inspection with approval. This failed practice had the widespread potential for more than minimal harm for all 50 residents. Findings: On 12/04/19 at 1:45 p.m., the administrator was asked about the annual fire marshal inspection. He stated he would be replacing/upgrading the center's system and had not had an annual/current State Fire Marshal inspection.	R 322		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC1802	GOLDEN LIFE RESIDENTIAL

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. 32388	12/04/2019	12/05/2019	0.50	0.00	8.75	0.00	5.00	4.00
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9.								
10.								
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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 23 2019

Oklahoma State Department of Health
Creating a State of Health

January 27, 2020

License Number: RC1802
Survey Event ID: PZW411

Mr. Randy McKinney, Administrator
Golden Life Residential Care
P.O. Box 180
Bluejacket, OK 74333

Dear Mr. McKinney:

On December 5, 2019, a State Licensure survey was conducted at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 20, 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/jt

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
	RC1802	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIFE RESIDENTIAL	408 NORTH EAST CENTER BLUEJACKET, OK 74333

(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
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Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ray McKay 6899 — TITLE: Owner — (X6) DATE: 1-21-20

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
	RC1802	A. BUILDING _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 310 SS=F	310:680-5-1 (10) GENERAL CRITERIA - SAFETY HAZARDS Residential care homes must meet or exceed the following requirements: (10) Each residential care home shall be free from safety hazards. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to be free from safety hazards of 2 broken windows with glass hanging	R 310	RECEIVED JAN 23 2020 Long Term Care Repaired Gloss Inspected all windows Throughit out The Facility, no other Problems.	12-10-19

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Oklahoma State Department of Health
Creating a State of Health

March 9, 2020

License Number: RC1802
Survey Event ID: PZW412

Mr. Randy McKinney,
Golden Life Residential Care
P.O. Box 180
Bluejacket, OK 74333

Dear Mr. McKinney:

Enclosed is the summary of deficiencies following the revisit conducted at your Residential Care facility on **February 26, 2020**. This revisit found that deficiencies identified at the time of your **December 5, 2019** survey have not been corrected.

The deficiencies cited on **February 26, 2020** resulted in deficiencies representing the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the space provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

(1) A statement of exactly how the facility has or intends to correct each deficiency.

(2) The method of correction. This includes who is responsible for the correction.

(3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

(4) A reasonable date of correction, which will normally be within 30 days of this notice.

NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **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 this completed form for your files.

In the event that we find your Plan of Correction unacceptable, you will be notified of the reason(s) it is not acceptable and we will request another Plan of Correction. If your plan of correction is acceptable, there will be no acknowledgement. We will conduct a revisit in accordance with your stated correction dates. If you have any questions concerning this letter, please contact me at (405) 271-6868.

In accordance with O.S. 63 830,1, 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 833-RC). 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 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 calendar days from receipt of the State Form deficiency statement. 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.

Sincerely,

Katie Stagner

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

SD/kgs
Enclosure

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
	RC1802	A. BUILDING: _____ B. WING _____	R 02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIFE RESIDENTIAL	408 NORTH EAST CENTER BLUEJACKET, OK 74333

(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
{R 000}	INITIAL COMMENTS A follow-up survey was conducted on 02/26/20. The census was 48. The following deficient practice was re-cited.	{R 000}		
{R 322} SS=F	310:680-5-5 FIRE SAFETY Each residential care home shall provide documentation that the State Fire Marshal or the State Fire Marshal's representative has inspected and approved the home prior to issuance of an initial license. Each residential care home with more than six beds shall provide documentation of annual inspection and approval prior to issuance of a license renewal. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to provide documentation the Oklahoma State Fire Marshal or their representative completed an annual inspection with approval. This failed practice had the widespread potential for more than minimal harm for all 48 residents. Findings: The administrator was asked about the annual fire marshal inspection. He stated he had replaced and upgraded the center's system. He provided documentation related to the changes. Documentation from the Oklahoma Fire Marshal was provided, however the fire marshal documentation still required a permit and will not be completed/cleared until then.	{R 322}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC1802	GOLDEN LIFE RESIDENTIAL

Type of Survey (select all that apply)

2	D			

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. SV 32388	02/26/2020	02/26/2020	0.25	0.00	1.75	0.00	4.25	2.00
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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

September 3, 2020

License Number: RC1802
Survey Event ID: PZW412

Mr. Randy McKinney
Golden Life Residential Care
P.O. Box 180
Bluejacket, OK 74333

Dear Mr. McKinney:

On **February 26, 2020**, a State Licensure survey was conducted at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **March 15, 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

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.09.03 10:50:14 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

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
	RC1802	A. BUILDING: _____ B. WING _____	R 02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIFE RESIDENTIAL	408 NORTH EAST CENTER BLUEJACKET, OK 74333

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

Raymond Kay — Admn - Owner — 3-15-20

Golden Life Res Care
Po Box 180
Bluejacket Ok 74333

Jan 4th the facility contacted our company to do our annual inspection on the alarm system at the facility. Upon their inspection we found that half of the facility was not working. Because of the age of the system, we could not find parts to fix it.

Our fire alarm company installed a new system.

Our facility contacted the fire marshal's office on 1/16/20 to do our state inspection. We explained to them what we had done to make sure the whole facility was working. Their response was that because this was a new system that it would have to go through their plan review system and have to be permit filed.

We contacted the fire alarm company and they summited a floor plan and where all units was.

We are waiting on the Fire Marshal's Office to do their part. When they get done they told us that they would set up appointment to do their inspection.

In waiting on the Fire Marshal Office we did an inspection on the alarm system and the sprinkler system and everything works. They green tagged both systems..

All we are waiting on is the Fire Marshal's office. When they get done we will furnish a copy to the Health Dept.

Randy McKinney Administrator