



Delivery via email to: goldrescare@gmail.com

July 2, 2021

License Number: RC1802
Survey Event ID: SIT411

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

Dear Mr. McKinney:

Enclosed is the summary of deficiencies from the complaint investigation conducted at your Residential Care facility on **June 25, 2021**.

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 spaces provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

- A statement of exactly how the facility has or intends to correct each deficiency.
- The method of correction. This includes who is responsible for the correction.
- 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.
- 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) 426-8200.



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) 426-8200 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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) 426-8200.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.07.02 14:49:56 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Golden Life Residential
Address: 408 North East Center
City, State, Zip: Bluejacket OK 74333
Provider #: RC1802
Complaint #: OK00056596
Investigation Date(s): 06/24/21 and 06/25/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to ensure residents: had the right to privately voice grievances to their ombudsman; and had the right to make medical decisions.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, June 24, 2021 at 7:10 a.m.

A sample of eight 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R149 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "Billie Seeman", written over a horizontal line.

Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/29/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Golden Life Residential
Address: 408 North East Center
City, State, Zip: Bluejacket OK 74333
Provider #: RC1802
Complaint #: OK00057149
Investigation Date(s): 06/24/21 and 06/25/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to ensure a safe environment by maintaining the building/home.	S
2. The home failed to have and or implement their abuse policy.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, June 24, 2021 at 7:10 a.m.

A sample of nine 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R356, R358 and R359 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to abuse was conducted.

Residents interacted with each other and the staff appropriately during the survey.

Residents were asked if they felt safe in the home. They stated yes. Residents were asked if other residents were abusive. They stated the resident who had anger outbursts was no longer living in the home. The residents stated they were not afraid of the other residents. One resident stated he was generally afraid of people and was not having problems with the other residents.

The administrator stated the resident who had become abusive was removed from the home. He stated he was not aware of residents being afraid of any other residents.

Clinical records, resident council, state reportable incident reports, policy and procedures were reviewed. According to the records the home followed its abuse policy.

At the time of the survey no deficient practice related to abuse was cited.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/29/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Golden Life Residential
Address: 408 North East Center
City, State, Zip: Bluejacket Ok
Provider #: RC1802
Complaint #: OK00057255
Investigation Date(s): 06/24/21 and 06/25/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to operate with a current license.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, June 24, 2021 at 7:10 a.m.

A sample of ten 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R202 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation enter number. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink that reads "Billie Seeman". The signature is written in a cursive, flowing style. Below the signature is a horizontal line.

Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/29/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Golden Life Residential
Address: 408 North East Center
City, State, Zip: Bluejacket OK 74333
Provider #: RC1802
Complaint #: OK00057265
Investigation Date(s): 06/24/21 and 06/25/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to protect resident property from misappropriation and failed to provide a safe, clean, pest free environment.	S
2. The home failed to provide an abuse free environment.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, June 24, 2021 at 7:10 a.m.

A sample of nine 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R309, R351 and R361 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to abuse was conducted.

Residents were observed interacting with the staff working in the home. The residents did not appear to be afraid of the administrator or any other staff.

Residents stated they felt safe in the home. The residents were asked if they had been threatened by the home's staff or the administrator. They stated no. The residents denied being hit, pushed or yelled at by the staff.

The clinical records, state reportable incident reports, resident council, abuse policies and procedures were reviewed. The records revealed the staff followed their abuse policy.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/29/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 An abbreviated survey was conducted on 06/24/21 and 06/25/21 to investigate complaint #OK00056596, OK00057149, OK00057255, and OK00057265. Total Residents: 45	R 000		
R 149 SS=E	63 O.S. 1-1918.B.2. RIGHTS - Private communications Section 1-840. Other provisions applicable to residential care homes Residential care homes subject to the provisions of the Residential Care Act shall comply with the provisions of Sections 1-1909, 1-1910, 1-1914.1, 1-1914.2, 1-1915, 1-1917, 1-1918, 1-1919, 1-1920, 1-1921, 1-1922, 1-1924, 1-1926, 1-1927, 1-1930, 1-1939, 1-1940 and 1-1941 of this title. 63 O.S. 1-1918(B)2. Every resident shall have the right to have private communications, including telephonic communications and visits and consultations with the physician, attorney, meetings of family and resident groups or any other person or person of his choice, and may send and promptly receive, unopened, his personal mail. This Rule is not met as evidenced by: Based on interview it was determined the home failed to ensure residents were able to have private communication with the ombudsman for two (#1 and #2) of four residents who were reviewed for the right to private communication.	R 149		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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R 149	Continued From page 1 This had the potential to affect all 45 residents who resided in the home. Findings: On 06/24/21 at 9:24 a.m., resident #1 was asked if a private conversation with the ombudsman had been interrupted. The resident stated yes, the administrator came in the room while the resident was speaking with the ombudsman. The resident stated the administrator was listening at the door before he entered the room. At 9:35 a.m., resident #2 stated the administrator entered the room while the resident was speaking with the ombudsman and the administrator wanted to know what they were talking about. On 06/25/21 at 3:21 p.m., the administrator was asked if he allowed the residents to have private conversations with the ombudsman. He stated yes. He was asked if he interfered with interviews between the residents and the ombudsman. He stated he followed the ombudsman around to see which residents she was speaking with.	R 149		
R 202 SS=F	310:680-3-2 (a)(b) & (d)(1) LICENSES (a) Regular license. The license shall be issued for a twenty-four (24) month period expiring two years from date of issue. A license may be issued upon receipt of completed application, payment of license fee, and verification by the Department that the home complies with the Residential Care Standards and Regulation for Licensure, and the Residential Care Act. (b) Probationary license. If the applicant has not been previously licensed, or if the home is not in	R 202		

Oklahoma State Department of Health

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R 202	Continued From page 2 operation at the time the application is made, the Department shall issue a probationary license. A probationary license shall be valid for one hundred twenty (120) days unless sooner suspended or revoked by the Department. (d)(1) Conditional license. The Department may issue a conditional license to any residential care home in which it finds that a violation exists. The issuance of a conditional license shall revoke any license held by the residential care home. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to retain a current license. This had the potential to affect all 45 residents who resided in the home. Findings: On 06/24/21 at 7:19 a.m., an observation of the home's license documented an expiration date of 12/11/19. Employee #1 was asked where the home's current license was located. She stated, "I don't think he has another one." At 7:25 a.m., the administrator stated he did not have another license. He stated he	R 202		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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R 202	Continued From page 3 sent a renewal packet for his license in May 2020 and then sent another packet last week. He was asked if he attempted to contact anybody from the health department concerning the license for the home when he did not receive a license in May 2020. He stated no.	R 202		
R 215 SS=F	310:680-3-6 (a)(4) POSTING COMPLAINT PROCEDURE (a) Every residential care home shall conspicuously post in an area of its offices accessible to residents, employees and visitors, the following: (4) Complaint procedure, established by the Nursing Home Care Act and provided by the Department which includes name, address, and telephone number of a person within the Department who is authorized to receive complaints. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to conspicuously post a copy of the complaint procedure, established by the Nursing Home Care Act and provided by the Department which includes name, address, and telephone number of a person within the Department who was authorized to receive complaints, in an area accessible to residents, employees, and visitors. This had the potential to affect all 45 residents who resided in the home. Findings:	R 215		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 408 NORTH EAST CENTER BLUEJACKET, OK 74333		
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R 215	Continued From page 4 On 06/25/21 at 3:04 p.m., the administrator was asked where the complaint procedure was posted. He looked on the wall by his office in the hall and stated it was usually posted here. He stated the residents sometimes removed it. The complaint procedure was not posted anywhere in the building.	R 215		
R 242 SS=E	310:680-3-8 (c) RESIDENTS' COUNCIL (c) The council shall meet at least monthly. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure the resident council met at least monthly. This had the potential to affect all 45 residents who resided in the home. Findings: On 06/25/21 at 11:14 a.m., the resident council minutes were reviewed and revealed there had only been one resident council meeting. The last documented meeting was not dated. The administrator stated he knew the home had missed a few resident council meetings. At 11:27 a.m., resident #10 was asked if the residents' council meetings had been conducted monthly. He stated no. He stated it had been over a year since they had a resident council meeting.	R 242		
R 309 SS=F	310:680-5-1 (9) GENERAL CRITERIA - GOOD REPAIR Residential care homes must meet or exceed the	R 309		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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(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 309	Continued From page 5 following requirements: (9) Each residential care home shall be maintained in good repair for operation and appearance. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure the home was maintained in good repair for operation and appearance. This had the potential to affect all 45 residents who resided in the home. Findings: On 06/24/21 a tour of the home was conducted and the following observations were made: The outside of the home near the front entrance did not have siding or brick around the door or window and the front door was dirty. The finish on a toilet seat on the men's hall was rubbed off and brown and a hole was in the wall behind the toilet exposing the plumbing. A toilet tank lid was missing in a female resident room. The administrator was asked about the hole behind the toilet. He stated the pipes had been replaced. He stated the plumber was not finished. He also stated room 23 did not have hot water. A doorknob was missing on one of the doors marked as an exit. The door was difficult to open when it was closed all the way. The residents	R 309		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 408 NORTH EAST CENTER BLUEJACKET, OK 74333		
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R 309	Continued From page 6 were leaving the door cracked so they could get in and out of the door. In the front of the home the siding was hanging down in two areas. The resident halls were dim, the lights were partially working. On 06/25/21 at 3:20 p.m., the administrator was made aware of the findings. He stated repairs were needed.	R 309		
R 351 SS=E	310:680-7-3 INSECT AND RODENT CONTROL Methods shall be employed to prevent the entrance and harborage of insects, spiders, and rodents. Homes shall be kept free of insects, and rodents. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to have an effective pest control to prevent the harborage of bed bugs for five (#1, 2, 4, 5 and #8) of five sampled residents who resided in home. This had the potential to affect all 45 residents who resided in the home. Findings: A review of the pest control receipt, dated 06/24/21, documented the home was sprayed for general pest control. On 06/24/21 at 7:38 a.m., resident #7 stated the	R 351		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 408 NORTH EAST CENTER BLUEJACKET, OK 74333		
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R 351	Continued From page 7 home had bed bugs. The resident stated that was the reason the mattresses and box springs were outside. At 8:20 a.m., a pest control company was at the home. The technician stated he came once a month and sprayed for cockroaches, spiders and general pest control. He stated he had not sprayed for bed bugs. At 9:16 a.m., resident #5 was asked about bed bugs. The resident stated the room was sprayed for bed bugs recently. At 9:24 a.m., resident #1 stated there had been bed bugs in the room. At 9:35 a.m., resident #2 stated the home had bed bugs. At 9:40 a.m., resident #1, 2, 4 and #5's beds were observed with employee #1. All the beds observed had bed bugs live and/or dead. Employee #1 was asked if other residents had bed bugs. She stated yes. At 11:45 a.m., two residents had skin irritation on bilateral upper arms. Employee #1 stated the two residents who had skin irritation on bilateral arms had been treated for bed bug bites. Employee #1 removed the covers on resident #8's bed and two live bed bugs were observed. On 06/25/21 at 10:07 a.m., the administrator was spraying the inside of the home for bed bugs with an insect control pesticide intended for outdoor use. The administrator was asked how long the home had bed bugs. He stated around six months. The	R 351		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 8 administrator stated he was treating it himself because it was too expensive to hire someone. He stated he spoke with an exterminator yesterday because the current bed bug treatment was not working.	R 351		
R 356 SS=E	310:680-7-5 (a) HOUSEKEEPING (a) The interior and exterior of the home shall be safe, clean and sanitary. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure the exterior of the home was kept safe in regards to the wooden and cement porches located at several entrances to the home. This had the potential to affect all 45 residents who resided at the home. Findings: On 06/24/21 at 7:15 a.m., during a tour of the grounds the front wrap around wooden porch was sunken in the middle in front of a doorway accessible to the residents. The porch was leaning on one side and did not have railing around that side of the porch. A wooden porch with steps on the back of the house had a missing handrail and rotted wood.	R 356		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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R 356	Continued From page 9 The wooden ramp leading out to the smoking area had a handrail that was able to be moved and some of the wooden planks sunk down when stepped on. The porch directly in front of the door had cinderblock steps which moved slightly when stepped on. The cement step leading up to the porch was missing part of the concrete and had one metal handrail. The front porch was missing concrete on the edge. At 9:24 a.m., resident #1 stated the ramp to the smoking area was not stable. The resident stated, "I almost fell through." The resident stated it happened about a week ago. On 06/25/21 at 9:58 a.m., resident #9 went up the wooden stairs on the front wrap around porch and entered the home. At 3:20 p.m., the administrator stated he was going to remove the porch and agreed repairs needed to be done to the home.	R 356		
R 358 SS=F	310:680-7-5 (c) HOUSEKEEPING (c) Floors and floor coverings shall be clean and in good condition. Floor polishes shall provide for a non-slip finish. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure the carpet	R 358		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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(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 358	Continued From page 10 in the common area and hallways and the vinyl flooring in the day room were maintained in good condition. This had the potential to affect all 45 residents who resided in the home. Findings: On 06/24/21 at 7:20 a.m., the carpet in the common area was stained in multiple areas and was coming apart in various areas of the room creating trip hazards. The entrance to some of the resident rooms had unraveling carpet. The vinyl flooring in the day room had several areas with the vinyl coming away from the floor creating trip hazards. A large area of vinyl was missing, exposing the subfloor. Employee #1 was asked how long the floor had been in the current condition. She stated four years. On 06/25/21 at 3:25 p.m., the administrator stated he planned to replace the carpet and vinyl.	R 358		
R 359 SS=E	310:680-7-5 (d) HOUSEKEEPING (d) Walls and ceilings shall be in good condition and shall be cleaned regularly. All homes shall have walls capable of being cleaned. This Rule is not met as evidenced by: Based on observation and interview it was determined the center failed to ensure the walls and ceiling were in good condition, cleaned regularly and were able to be cleaned. This had the potential to affect all 45 residents who resided in the home.	R 359		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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R 359	Continued From page 11 Findings: On 06/24/21 during a tour of the home, exposed walls and sheetrock were in the dining area. The dining room walls did not have baseboards. The finished walls in the dining room were dirty along with the walls in the hallway. At 9:55 a.m., employee #1 stated the blackened areas in the creases between the ceiling and the walls in the resident rooms looked like bed bug nests. On 06/25/21 at 10:26 a.m., resident #8's room was observed to have dirty walls. The end of the hall on one of the men's hall had a hole in the wall. The bathroom on the men's hall had a hole in the wall behind the toilet. At 12:10 p.m., the bathroom ceiling in the medication room was black with water damage and had a musty smell. The administrator stated they had a leak and the ceiling needed to be replaced. At 2:44 p.m., the cook observed the unfinished dining room walls and the dirty walls. He was asked why the walls were not finished. He stated the administrator was adding on to the home. He was asked who was responsible for cleaning the walls. He stated which ever resident they could pay to clean them.	R 359		
R 361 SS=E	310:680-7-5 (f) HOUSEKEEPING (f) Home and surrounding areas shall be kept free from refuse, discarded furniture, and old newspaper.	R 361		

Oklahoma State Department of Health

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R 361	Continued From page 12 Combustibles such as cleaning rags and compounds must be kept in closed metal containers in areas away from residents' rooms. No items shall be stored in the hot water heater closet or furnace closet. This Rule is not met as evidenced by: Based on observation and interview it was determined the home failed to ensure discarded furniture and refuse was not stored around the grounds of the home. This had the potential to affect all 45 residents who resided in the home. Findings: On 06/24/21 at 7:37 a.m., during a tour of the outside of the home the following observations were made: two box springs were leaning against a picnic table; a screen was laying on the ground near wooden stairs; broken metal patio chair was located on a side porch; three box springs and a mattress were located near another back entrance along with bedding on the ground; a screen door was on the ground at the bottom of wooden steps and two box springs and a mattress were leaning up against the brick exterior wall in the back of the home; a broken wooden chair was on the side of the	R 361		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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R 361	Continued From page 13 building near a wooden ramp, multiple pieces of furniture were at the top of the ramp on the side of the building; a washing machine was on the porch and building materials were located around the front of the house and; A metal building partially collapsed was in the back of the home with multiple trash bags and aluminum cans. On 06/25/21 at 3:21 p.m., the administrator was asked about the findings. He stated the metal shed was where the aluminum cans used to be stored and the metal shed had been damaged by the wind. The administrator stated he was in the process of tearing off the front porch to expand the front dining room area. He agreed with the observations of the outside of the home. He stated some of the box springs had been removed.	R 361		

REPORT REVISED

Delivery via email to: goldrescare@gmail.com

July 26, 2021

Survey Event ID: SIT411

Mr. Randy McKinney
Golden Life Residential
408 North East Center
Bluejacket, OK 74333

Dear Mr. McKinney:

On **June 25, 2021**, agents from our office concluded an investigation at your facility. You were advised of the findings of that investigation in our notice of **July 2, 2021**.

The original investigative report has been revised during administrative review of this case. A copy of the corrected investigation report is included. Deficiencies identified during the investigation are not affected by these corrections and a new plan of correction is not required. The corrected investigation report is being provided for your records and no additional action on your part is required at this time.

If we can be of any further assistance, please contact us at 405-426-8200.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.07.26 14:07:28 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

**AMENDED INVESTIGATIVE REPORT
LICENSURE**

Facility: Golden Life Residential
Address: 408 North East Center
City, State, Zip: Bluejacket Ok
Provider #: RC1802
Complaint #: OK00057255
Investigation Date(s): 06/24/21 and 06/25/21

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The home failed to operate with a current license.	S
2. The home failed to ensure residents were not exploited and their funds were not misappropriated.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, June 24, 2021 at 7:10 a.m.

A sample of ten 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R202 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to misappropriation of resident funds was conducted.

The residents' funds were observed with the administrator. The residents had personal belongings, cigarettes, snacks and soda they had purchased with their funds.

Residents were able to state the amount of their monthly income, rent and money provided to them after the rent was paid. The residents stated they received their stimulus money and their monthly income.

The bank statements, deposits, expenditures and actual cash on hand for three residents were reviewed. The balances were reconciled and were found to be accurate.

No deficient practice for misappropriation of funds was found at the time of the survey.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/29/2021



OKLAHOMA
State Department
of Health

Delivery via email to: goldrescare@gmail.com

July 28, 2021

License Number: RC1802
Survey Event ID: SIT411

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

Dear Mr. McKinney:

On **June 25, 2021**, agents from our office completed a complaint investigation at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **Tag R149 and R202:** This POC does not address how the deficient practice will be corrected.
- **Tag R359:** This POC does not address how the deficient practice of the dirty walls will be corrected.
- **Tags R215, R242, R309, R351, R356, R358 and R361:** The POC for these tags is accepted with three of the tags requesting more than thirty days, but less than sixty days to have the corrections done.

An amended plan of correction is due within 10 days of receipt of this notice.

Sincerely,

Tempal Killman

Digitally signed by Tempal
Killman
Date: 2021.07.28 15:47:36
-05'00'

Tempal Killman, Administrative Assistant
Long Term Care | Enforcement
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 408 NORTH EAST CENTER BLUEJACKET, OK 74333
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R 000 INITIAL COMMENTS

An abbreviated survey was conducted on 06/24/21 and 06/25/21 to investigate complaint #OK00056596, OK00057149, OK00057255, and OK00057265.

Total Residents: 45

R 149 63 O.S. 1-1918.B.2. RIGHTS - Private SS=E communications

Section 1-840. Other provisions applicable to residential care homes

Residential care homes subject to the provisions of the Residential Care Act shall comply with the provisions of Sections 1-1909, 1-1910, 1-1914.1, 1-1914.2, 1-1915, 1-1917, 1-1918, 1-1919, 1-1920, 1-1921, 1-1922, 1-1924, 1-1926, 1-1927, 1-1930, 1-1939, 1-1940 and 1-1941 of this title.

63 O.S. 1-1918(B)2. Every resident shall have the right to have private communications, including telephonic communications and visits and consultations with the physician, attorney, meetings of family and resident groups or any other person or person of his choice, and may send and promptly receive, unopened, his personal mail.

This Rule is not met as evidenced by:
Based on interview it was determined the home failed to ensure residents were able to have private communication with the ombudsman for two (#1 and #2) of four residents who were reviewed for the right to private communication.

R 000

R 149

RECEIVED

JUL 27 2021

Long Term Care

ON a Visit From The Ombudsman. She Came to the Facility unannounced to staff. We Had a policy that no one was to Enter The Facility Because of The Covid Virus. I came to The Facility a little later and a Resident Told me That Some Lady went down The Hall. I went to See who it was. I Entered Canteen Room and she was in There. I made a comment oh it is you and Left The Room

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6599

SIT411

TITLE

Rogmily Ann

(X6) DATE

7-22-21

If continuation sheet 1 of 14

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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R 149	Continued From page 1 This had the potential to affect all 45 residents who resided in the home. Findings: On 06/24/21 at 9:24 a.m., resident #1 was asked if a private conversation with the ombudsman had been interrupted. The resident stated yes, the administrator came in the room while the resident was speaking with the ombudsman. The resident stated the administrator was listening at the door before he entered the room. At 9:35 a.m., resident #2 stated the administrator entered the room while the resident was speaking with the ombudsman and the administrator wanted to know what they were talking about. On 06/25/21 at 3:21 p.m., the administrator was asked if he allowed the residents to have private conversations with the ombudsman. He stated yes. He was asked if he interfered with interviews between the residents and the ombudsman. He stated he followed the ombudsman around to see which residents she was speaking with.	R 149	we have never not allowed her to have visits with any Residents. I do have issues about her telling Residents that they do not have to live by the How-Rules and telling Residents that they don't have to take their meds.	
R 202 SS=F	310:680-3-2 (a)(b) & (d)(1) LICENSES (a) Regular license. The license shall be issued for a twenty-four (24) month period expiring two years from date of issue. A license may be issued upon receipt of completed application, payment of license fee, and verification by the Department that the home complies with the Residential Care Standards and Regulation for Licensure, and the Residential Care Act. (b) Probationary license. If the applicant has not been previously licensed, or if the home is not in	R 202		

RECEIVED
JUL 27 2021
Long Term Care

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 408 NORTH EAST CENTER BLUEJACKET, OK 74333
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R 202 Continued From page 2

operation at the time the application is made, the Department shall issue a probationary license. A probationary license shall be valid for one hundred twenty (120) days unless sooner suspended or revoked by the Department.

(d)(1) Conditional license. The Department may issue a conditional license to any residential care home in which it finds that a violation exists. The issuance of a conditional license shall revoke any license held by the residential care home.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, it was determined the center failed to retain a current license.

This had the potential to affect all 45 residents who resided in the home.

Findings:

On 06/24/21 at 7:19 a.m., an observation of the home's license documented an expiration date of 12/11/19. Employee #1 was asked where the home's current license was located. She stated, "I don't think he has another one."

At 7:25 a.m., the administrator stated he did not have another license. He stated he

R 202

We Sent a packet to
The Health Dept on 5-21-20
I don't know what happened
To That packet
We Sent another packet
ON 6-11-21
By Registered Mail.
We got an Email from
Health Dept 6-23-21
stating they have the
packet

6-11-21



Oklahoma State Department of Health

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R 202	Continued From page 3 sent a renewal packet for his license in May 2020 and then sent another packet last week. He was asked if he attempted to contact anybody from the health department concerning the license for the home when he did not receive a license in May 2020. He stated no.	R 202	RECEIVED JUL 27 2021 Long Term Care We are Building a Box with Glass front on it so Posted stuff will Not Be Removed By Residents 8-15-21 We Have posted a copy of Complaint Procedure and Told Residents Not to Take off mail 7-1-21		
R 215	310:680-3-6 (a)(4) POSTING COMPLAINT PROCEDURE (a) Every residential care home shall conspicuously post in an area of its offices accessible to residents, employees and visitors, the following: (4) Complaint procedure, established by the Nursing Home Care Act and provided by the Department which includes name, address, and telephone number of a person within the Department who is authorized to receive complaints. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to conspicuously post a copy of the complaint procedure, established by the Nursing Home Care Act and provided by the Department which includes name, address, and telephone number of a person within the Department who was authorized to receive complaints in an area accessible to residents, employees, and visitors. This had the potential to affect all 45 residents who resided in the home. Findings:	R 215			

Oklahoma State Department of Health

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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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R 215 Continued From page 4

On 06/25/21 at 3:04 p.m., the administrator was asked where the complaint procedure was posted. He looked on the wall by his office in the hall and stated it was usually posted here. He stated the residents sometimes removed it.

The complaint procedure was not posted anywhere in the building.

R 242 310:680-3-8 (c) RESIDENTS' COUNCIL
SS=E

(c) The council shall meet at least monthly.

This Rule is not met as evidenced by:
Based on interview and record review, it was determined the home failed to ensure the resident council met at least monthly. This had the potential to affect all 45 residents who resided in the home.

Findings:

On 06/25/21 at 11:14 a.m., the resident council minutes were reviewed and revealed there had only been one resident council meeting. The last documented meeting was not dated. The administrator stated he knew the home had missed a few resident council meetings.

At 11:27 a.m., resident #10 was asked if the residents' council meetings had been conducted monthly. He stated no. He stated it had been over a year since they had a resident council meeting.

R 309 310:680-5-1 (9) GENERAL CRITERIA - GOOD
SS=F REPAIR

Residential care homes must meet or exceed the

R 215

R 242

R 309

RECEIVED

JUL 27 2021

Long Term Care

Resident Council is done
By Resident.

I Have given Direction To
a Staff Member to put
This on Her Calendar so
Each month The Residents
Can have their meeting

7-16-21

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 408 NORTH EAST CENTER BLUEJACKET, OK 74333
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R 309 Continued From page 5

following requirements:

(9) Each residential care home shall be maintained in good repair for operation and appearance.

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the home failed to ensure the home was maintained in good repair for operation and appearance.

This had the potential to affect all 45 residents who resided in the home.

Findings:

On 06/24/21 a tour of the home was conducted and the following observations were made:

The outside of the home near the front entrance did not have siding or brick around the door or window and the front door was dirty.

The finish on a toilet seat on the men's hall was rubbed off and brown and a hole was in the wall behind the toilet exposing the plumbing. A toilet tank lid was missing in a female resident room.

The administrator was asked about the hole behind the toilet. He stated the pipes had been replaced. He stated the plumber was not finished. He also stated room 23 did not have hot water.

A doorknob was missing on one of the doors marked as an exit. The door was difficult to open when it was closed all the way. The residents

R 309

The Area in Front of Door
is going to be Remodeled
So to Add more Room
In Dining Room

8-31-21

A Temporary Step Has Been
Installed for Safety

7-10-21

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Long Term Care

We Replaced Toilet Seat
and Painted That Room
Fixed Exposed Plumbing +
Apply Base Boards

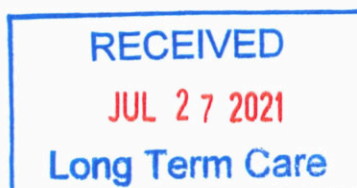
7-14-21

We put New door Knob
this day Thursday, Henry

6-25-21

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1802	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	Continued From page 6 were leaving the door cracked so they could get in and out of the door. In the front of the home the siding was hanging down in two areas. The resident halls were dim, the lights were partially working. On 06/25/21 at 3:20 p.m., the administrator was made aware of the findings. He stated repairs were needed.	R 309	We Fixed the Siding 7-1-21 We Fixed General Light New Ballas & Bulbs	
R 351	310:680-7-3 INSECT AND RODENT CONTROL SS=E Methods shall be employed to prevent the entrance and harborage of insects, spiders, and rodents. Homes shall be kept free of insects, and rodents. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to have an effective pest control to prevent the harborage of bed bugs for five (#1, 2, 4, 5 and #8) of five sampled residents who resided in home. This had the potential to affect all 45 residents who resided in the home. Findings: A review of the pest control receipt, dated 06/24/21, documented the home was sprayed for general pest control. On 06/24/21 at 7:38 a.m., resident #7 stated the	R 351	We Have Replaced Several Box Springs & Mat. We Found Some Spray That Will Kill Live Bugs & Kill the Eggs. We Have Sprayed every Room and Followed up Every 10 days, and Will Continue this Regimen Till Bugs are gone First Spray was 6-27-21	



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIFE RESIDENTIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 408 NORTH EAST CENTER BLUEJACKET, OK 74333
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R 351 Continued From page 7

home had bed bugs. The resident stated that was the reason the mattresses and box springs were outside.

At 8:20 a.m., a pest control company was at the home. The technician stated he came once a month and sprayed for cockroaches, spiders and general pest control. He stated he had not sprayed for bed bugs.

At 9:16 a.m., resident #5 was asked about bed bugs. The resident stated the room was sprayed for bed bugs recently.

At 9:24 a.m., resident #1 stated there had been bed bugs in the room.

At 9:35 a.m., resident #2 stated the home had bed bugs.

At 9:40 a.m., resident #1, 2, 4 and #5's beds were observed with employee #1. All the beds observed had bed bugs live and/or dead. Employee #1 was asked if other residents had bed bugs. She stated yes.

At 11:45 a.m., two residents had skin irritation on bilateral upper arms. Employee #1 stated the two residents who had skin irritation on bilateral arms had been treated for bed bug bites. Employee #1 removed the covers on resident #8's bed and two live bed bugs were observed.

On 06/25/21 at 10:07 a.m., the administrator was spraying the inside of the home for bed bugs with an insect control pesticide intended for outdoor use.

The administrator was asked how long the home had bed bugs. He stated around six months. The

R 351

Second Spray

7-7-21

Third Spray

7-17-21

So on -

We Also Have Bought Electronic Devices that is Supposed to Help Keep Pest out

7-12-21

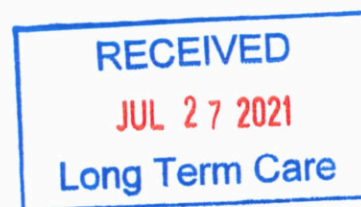
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R 351	Continued From page 8 administrator stated he was treating it himself because it was too expensive to hire someone. He stated he spoke with an exterminator yesterday because the current bed bug treatment was not working.	R 351		
R 356 SS=E	310:680-7-5 (a) HOUSEKEEPING (a) The interior and exterior of the home shall be safe, clean and sanitary. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure the exterior of the home was kept safe in regards to the wooden and cement porches located at several entrances to the home. This had the potential to affect all 45 residents who resided at the home. Findings: On 06/24/21 at 7:15 a.m., during a tour of the grounds the front wrap around wooden porch was sunken in the middle in front of a doorway accessible to the residents. The porch was leaning on one side and did not have railing around that side of the porch. A wooden porch with steps on the back of the house had a missing handrail and rotted wood.	R 356		



Porch was Repaired
and Block-ed up and
Secured,

7-3-21

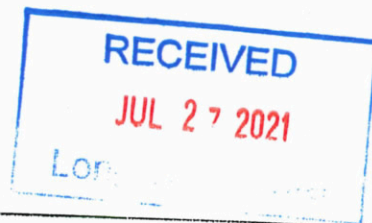
Oklahoma State Department of Health

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R 356	Continued From page 9 The wooden ramp leading out to the smoking area had a handrail that was able to be moved and some of the wooden planks sunk down when stepped on. The porch directly in front of the door had cinderblock steps which moved slightly when stepped on. The cement step leading up to the porch was missing part of the concrete and had one metal handrail. The front porch was missing concrete on the edge. At 9:24 a.m., resident #1 stated the ramp to the smoking area was not stable. The resident stated, "I almost fell through." The resident stated it happened about a week ago. On 06/25/21 at 9:58 a.m., resident #9 went up the wooden stairs on the front wrap around porch and entered the home. At 3:20 p.m., the administrator stated he was going to remove the porch and agreed repairs needed to be done to the home.	R 356	We Installed New Railing To Ramp leading out to smoking Area	7-7-21
R 358 SS=F	310:680-7-5 (c) HOUSEKEEPING (c) Floors and floor coverings shall be clean and in good condition. Floor polishes shall provide for a non-slip finish. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure the carpet	R 358		

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R 358	Continued From page 10 in the common area and hallways and the vinyl flooring in the day room were maintained in good condition. This had the potential to affect all 45 residents who resided in the home. Findings: On 06/24/21 at 7:20 a.m., the carpet in the common area was stained in multiple areas and was coming apart in various areas of the room creating trip hazards. The entrance to some of the resident rooms had unraveling carpet. The vinyl flooring in the day room had several areas with the vinyl coming away from the floor creating trip hazards. A large area of vinyl was missing, exposing the subfloor. Employee #1 was asked how long the floor had been in the current condition. She stated four years. On 06/25/21 at 3:25 p.m., the administrator stated he planned to replace the carpet and vinyl.	R 358	<i>we Have bought New Carpet for Area waiting for Installers to put Down we Have Installed New Floor in Day Room Repainted Install Map Boards</i>	8-12-21 7-8-21
R 359 SS=E	310:680-7-5 (d) HOUSEKEEPING (d) Walls and ceilings shall be in good condition and shall be cleaned regularly. All homes shall have walls capable of being cleaned. This Rule is not met as evidenced by: Based on observation and interview it was determined the center failed to ensure the walls and ceiling were in good condition, cleaned regularly and were able to be cleaned. This had the potential to affect all 45 residents who resided in the home.	R 359		



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R 359	Continued From page 11 Findings: On 06/24/21 during a tour of the home, exposed walls and sheetrock were in the dining area. The dining room walls did not have baseboards. The finished walls in the dining room were dirty along with the walls in the hallway. At 9:55 a.m., employee #1 stated the blackened areas in the creases between the ceiling and the walls in the resident rooms looked like bed bug nests. On 06/25/21 at 10:26 a.m., resident #8's room was observed to have dirty walls. The end of the hall on one of the men's hall had a hole in the wall. The bathroom on the men's hall had a hole in the wall behind the toilet. At 12:10 p.m., the bathroom ceiling in the medication room was black with water damage and had a musty smell. The administrator stated they had a leak and the ceiling needed to be replaced. At 2:44 p.m., the cook observed the unfinished dining room walls and the dirty walls. He was asked why the walls were not finished. He stated the administrator was adding on to the home. He was asked who was responsible for cleaning the walls. He stated which ever resident they could pay to clean them.	R 359	this Area is under Constaction to Inlay- Dinning Room Eysced Finish 8-31-21 we Have Covered The Exposed Area 7-10-21 we will Have this Repaired By 7-25-21	
R 361 SS=E	310:380-7-5 (f) HOUSEKEEPING (f) Home and surrounding areas shall be kept free from refuse, discarded furniture, and old newspaper.	R 361		

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