

Delivery via email to: homesteadrescare@yahoo.com

March 20, 2025

License Number: RC1811
Survey Event ID: **5LLY11**

Mr. Ron Kelley, Administrator
Homestead Residential Care
P.O. Box 554
Vinita, OK 74301

Dear Mr. Kelley:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey with complaint investigations at your facility on **March 13, 2025**.

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:

- 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.

Respectfully,



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

Enclosure

INVESTIGATIVE REPORT

Facility: Homestead Residential Care
Address: 35284 South 4440 Road
City, State, Zip: Vinita, OK, 74301, Craig
Provider #: RC1811
Complaint #: OK00066448
Investigation Dates: 03/12/25 through 03/13/25

ALLEGATION(S)
The home failed to ensure resident funds were not misappropriated.
The home failed to allow residents and/or their legal guardian to manage their finances.
The home failed to ensure the physical environment was maintained in good repair and adequate enclosed storage space was provided for personal belongings.
The home failed to ensure the grievance policy was adequate and the resident would not be retaliated against.

An unannounced on-site investigation was initiated 03/12/2025 at 8:45 a.m.

A sample of 13 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs, staff/resident interactions, and the presence of obnoxious and/or foul odors.

Resident council minutes, incident reports, policies and procedures were reviewed. Resident records were also reviewed.

Staff members, the ombudsman, and residents were interviewed regarding resident funds, grievances, and the environment.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

INVESTIGATIVE REPORT

Facility: Homestead Residential Care
Address: 35284 South 4440 Road
City, State, Zip: Vinita, OK, 74301, Craig
Provider #: RC1811
Complaint #: OK00067208
Investigation Dates: 03/12/25 through 03/13/25

ALLEGATION
The facility failed to ensure residents were not sexually, physically or psychosocially abused.

An unannounced on-site investigation was initiated 03/12/2025 at 8:45 a.m.

A sample of 13 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 other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs, staff/resident interactions, and the presence of obnoxious and/or foul odors.

Resident council minutes, incident reports, policies and procedures were reviewed. Resident records were also reviewed.

Staff members, the ombudsman, and residents were interviewed regarding abuse.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

INVESTIGATIVE REPORT

Facility: Homestead Residential Care
Address: 35284 South 4440 Road
City, State, Zip: Vinita, OK, 74301, Craig
Provider #: RC1811
Complaint #: OK00068361
Investigation Dates: 03/12/25 through 03/13/25

ALLEGATION

The facility failed to ensure residents were not physically, verbally, or psychosocially abused.
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An unannounced on-site investigation was initiated 03/12/2025 at 8:45 a.m.

A sample of 13 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 other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs, staff/resident interactions, and the presence of obnoxious and/or foul odors.

Resident council minutes, incident reports, policies and procedures were reviewed. Resident records were also reviewed.

Staff members, the ombudsman, and residents were interviewed regarding abuse.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

INVESTIGATIVE REPORT

Facility: Homestead Residential Care
Address: 35284 South 4440 Road
City, State, Zip: Vinita, OK, 74301, Craig
Provider #: RC1811
Complaint #: OK00068889
Investigation Dates: 03/12/25 through 03/13/25

ALLEGATION(S)
The center failed to ensure residents were not physically, verbally or psychosocially abused.
The center failed to ensure adequate staff to meet the needs of the resident.
The center failed to have and/or implement an effective pest control program and failed to ensure a safe, clean and comfortable environment.
The center failed to ensure medications were stored in a secure manner.

An unannounced on-site investigation was initiated 03/12/2025 at 8:45 a.m.

A sample of 13 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs, staff/resident interactions, and the presence of obnoxious and/or foul odors. A medication pass was also observed.

Resident council minutes, pest control records, incident reports, policies and procedures were reviewed. Resident and staff records were also reviewed.

Staff members, the ombudsman, and residents were interviewed regarding abuse, medication, pests, and the environment.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

INVESTIGATIVE REPORT

Facility: Homestead Residential Care
Address: 35284 South 4440 Road
City, State, Zip: Vinita, OK, 74301, Craig
Provider #: RC1811
Complaint #: OK00077522
Investigation Dates: 03/12/25 through 03/13/25

ALLEGATION
The home failed to ensure residents were not physically abused.

An unannounced on-site investigation was initiated 03/12/2025 at 8:45 a.m.

A sample of 13 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs, staff/resident interactions, and the presence of obnoxious and/or foul odors.

Resident council minutes, incident reports, policies and procedures were reviewed. Resident records were also reviewed.

Staff members, the ombudsman, and residents were interviewed regarding abuse.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1811	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/13/2025
NAME OF PROVIDER OR SUPPLIER HOMESTEAD RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 35284 SOUTH 4440 ROAD VINITA, OK 74301		
(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 relicensure survey was conducted from 03/12/25 through 03/13/25. Complaint investigations (#OK00066448, OK00067208, OK00068361, OK00068889, and #OK00077522) were conducted in conjunction with the survey. Facility Census: 37 Listed below are abbreviations that will be used throughout this document. OSDH - Oklahoma State Department of Health	R 000		
R 249 SS=D	310:680-3-10 (b) ABUSE OR NEGLECT - REPORTING (b) Any individual who becomes aware of abuse or neglect of a resident shall report the matter immediately to the Department and comply with other reporting requirements provided in the O.S. Title 43A, section 10-104. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure allegations of abuse were reported to the OSDH for 1 (#3) of 13 sampled residents reviewed for abuse reporting. Certified nurse aide #1 reported 37 residents	R 249		

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: RC1811	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/13/2025
NAME OF PROVIDER OR SUPPLIER HOMESTEAD RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 35284 SOUTH 4440 ROAD VINITA, OK 74301		
(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 249	Continued From page 1 resided in the facility. Findings: An undated "Policy Regarding Accusation of Abuse and Neglect" policy, read in part, "In order to assure individuals/residents will be safe Homestead Residential Care prohibits abuse and neglect and if it does happen the following steps will be taken in order to provide protection for the individual making the allegation"... "The administrator will notify the following persons and agencies of the allegation"... "6. Department of Health." Resident #3 was admitted to the facility on 05/04/23 with diagnoses which included schizophrenia and seizure disorder. An undated and untitled facility document showed there was an allegation of physical abuse reported to facility staff involving the administrator and Resident #3. A review of the facility reported incidents from 04/01/24 through 03/13/25 did not show any allegations of abuse had been reported to the OSDH regarding Resident #3. On 03/13/25 at 2:10 p.m., residential care aide #1 stated the incident was not reported because Resident #3 stated they had made the allegation up because they were mad. They also stated any allegation of abuse should be reported. On 03/13/25 at 2:15 p.m., administrator #2 stated any allegation of abuse should be reported.	R 249		

Delivery via email to: Ron & Donna Kelley <homesteadrescare@yahoo.com>

April 2, 2025

License Number: RC1811
Survey Event ID: **5LLY11**

Mr. Ron Kelley, Administrator
Homestead Residential Care
P.O. Box 554
Vinita, OK 74301

Dear Mr. Kelley:

On **March 13, 2025**, agents from our office completed an inspection with complaint investigations 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:

- **R0249:** The plan of correction needs an educational component, and some type of monitoring put into place to assure that the deficient practice will not recur.

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

Respectfully,



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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1811	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/13/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOMESTEAD RESIDENTIAL CARE

**35284 SOUTH 4440 ROAD
VINITA, OK 74301**

(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 000 INITIAL COMMENTS

A relicensure survey was conducted from 03/12/25 through 03/13/25. Complaint investigations (#OK00066448, OK00067208, OK00068361, OK00068889, and #OK00077522) were conducted in conjunction with the survey.

Facility Census: 37

Listed below are abbreviations that will be used throughout this document.

OSDH - Oklahoma State Department of Health

R 000

All allegations reported to Administrator will be sent in a incident report to Department of Health and Sharon Reed will follow up and make sure sent in.

~~3/13/2025~~

3/14/2025

R 249 310:680-3-10 (b) ABUSE OR NEGLECT -
SS=D REPORTING

(b) Any individual who becomes aware of abuse or neglect of a resident shall report the matter immediately to the Department and comply with other reporting requirements provided in the O.S. Title 43A, section 10-104.

R 249

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure allegations of abuse were reported to the OSDH for 1 (#3) of 13 sampled residents reviewed for abuse reporting.

Certified nurse aide #1 reported 37 residents

Oklahoma State Department of Health

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

TITLE

Polmin.

(X8) DATE

3/27/25

STATE FORM

5LLY11

If continuation sheet 1 of 2

Delivery via email to: Ron & Donna Kelley <homesteadrescare@yahoo.com>

April 16, 2025

License Number: RC1811
Survey Event ID: **5LLY11**

Mr. Ron Kelley, Administrator
Homestead Residential Care
P.O. Box 554
Vinita, OK 74301

Dear Mr. Kelley:

On **March 13, 2025**, agents from our office completed an inspection with 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:

- **R0249:** The POC was previously rejected for not having any monitoring in place. No monitoring is present in this Amended POC.

A 2nd amended plan of correction is due within 10 days of receipt of this notice.

Respectfully,



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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1811	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/13/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOMESTEAD RESIDENTIAL CARE

**35284 SOUTH 4440 ROAD
VINITA, OK 74301**

(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 000 INITIAL COMMENTS

A relicensure survey was conducted from 03/12/25 through 03/13/25. Complaint investigations (#OK00066448, OK00067208, OK00068361, OK00068889, and #OK00077522) were conducted in conjunction with the survey.

Facility Census: 37

Listed below are abbreviations that will be used throughout this document.

OSDH - Oklahoma State Department of Health

R 000

All allegations reported to Administrator will be sent in a incident report to Department of Health and Sharon Reed will follow up and make sure sent in.

~~3/13/2025~~

3/14/2025

R 249 310:680-3-10 (b) ABUSE OR NEGLECT -
SS=D REPORTING

(b) Any individual who becomes aware of abuse or neglect of a resident shall report the matter immediately to the Department and comply with other reporting requirements provided in the O.S. Title 43A, section 10-104.

R 249

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure allegations of abuse were reported to the OSDH for 1 (#3) of 13 sampled residents reviewed for abuse reporting.

Certified nurse aide #1 reported 37 residents

Oklahoma State Department of Health

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

TITLE

Polmin.

(X8) DATE

3/27/25

STATE FORM

5LLY11

If continuation sheet 1 of 2

Employee In-Service

Facility Homestead Residential Care

Date 3/14/2025

Training Topic Critical Incident Reporting Procedures,

Abuse & Neglect, Topics for criticals: ER visits,
Resident walk-offs, Incidents between residents, residents
complaints about other residents & employees. Documentation

Number of hours 1 1/2 HRS

Instructor(s) Bon Kelley / Donna Kelley

Names (signature)

Sharon Reed

Danelle Farmer

Daryl Chambers

Cladock

McKalla Bruffett

Justin Hendren

Bill Hurdle

Ami Victor

Mandy Walker

Delivery via email to: homesteadrescare@yahoo.com

April 24, 2025

License Number: RC1811
Survey Event ID: **5LLY11**

Mr. Ron Kelley, Administrator
Homestead Residential Care
P.O. Box 554
Vinita, OK 74301

Dear Mr. Kelley:

On **March 13, 2025**, a State Licensure survey with complaint investigations 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 **April 18, 2025**.

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) 426-8200.

Respectfully,



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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1811	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/13/2025

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOMESTEAD RESIDENTIAL CARE

35284 SOUTH 4440 ROAD

VINITA, OK 74301

(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 relicensure survey was conducted from 03/12/25 through 03/13/25. Complaint investigations (#OK00066448, OK00067208, OK00068361, OK00068889, and #OK00077522) were conducted in conjunction with the survey. Facility Census: 37 Listed below are abbreviations that will be used throughout this document. OSDH - Oklahoma State Department of Health	R 000	All allegations reported to Administrator will be sent in a incident report to Department of Health and Sharon Reed will follow up and make sure sent in. 3/13/2025 3/14/2025	
R 249 SS=D	310:680-3-10 (b) ABUSE OR NEGLECT - REPORTING (b) Any individual who becomes aware of abuse or neglect of a resident shall report the matter immediately to the Department and comply with other reporting requirements provided in the O.S. Title 43A, section 10-104. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure allegations of abuse were reported to the OSDH for 1 (#3) of 13 sampled residents reviewed for abuse reporting. Certified nurse aide #1 reported 37 residents	R 249	The Administrator will follow up on all incident reports to see they are sent in, and all allegations will be sent in on a incident report.	4/18/24

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

TITLE Admin.

(X6) DATE

3/27/25

If continuation sheet 1 of 2

4/18/25

Employee In-Service

Facility Homestead Residential Care
Date 3/14/2025
Training Topic Critical Incident Reporting Procedures,
Abuse & Neglect, Topics for criticals: ER visits,
Resident walk-offs, Incidents between residents, residents
complaints about other residents & employees. Documentation
Number of hours 1 1/2 HRS
Instructor(s) Ron Kelley / Donna Kelley

Names (signature)

Sharon Rood

Shanelle Farmer

Daryl Chambers

Chloe Beck

McKayla Bruffett

Justin Hendren

Bill Handle

Amy Vieler

Mandy Walker

Ron Kelley, Administrator

Delivery via email to: homesteadrescare@yahoo.com

May 6, 2025

License Number: RC1811
Survey Event ID: **5LLY12**

Mr. Ron Kelley, Administrator
Homestead Residential Care
35284 South 4440 Road
Vinita, OK 74301

Dear Mr. Kelley:

On **May 5, 2025**, an offsite/paper revisit was conducted for your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Residential Care Facility. The findings of that visit indicate that the deficiencies cited during your survey with complaints on **March 13, 2025**, have now been corrected and your facility is in compliance with licensure standards effective **April 18, 2025**.

If you have any questions concerning the information in this letter, please contact this office at (405) 426-8200.

Respectfully,



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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC1811	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 05/05/2025
NAME OF PROVIDER OR SUPPLIER HOMESTEAD RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 35284 SOUTH 4440 ROAD VINITA, OK 74301		
(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 offsite/paper revisit was conducted on 05/05/25. The facility was in substantial compliance.	{R 000}		

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