Oklahoma State Department of Health
Creating a State of Health

August 28, 2019

License Number: RC4601
Survey Event ID: 754O11

Ms. Cheri Martin, Administrator
North Fork Residential Care
P.O. Box 1710
Kingston, OK 73439

Dear Ms. Martin:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey at your facility on **August 15, 2019**.

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

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

The criteria for an acceptable plan of correction are:

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

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

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

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

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

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process.** Please retain a copy of this completed form for your files.

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

In accordance with O.S. 63 830.1, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833-RC). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

Sincerely,

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

SD/ldc
Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC4601	A BUILDING _____ B WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS RESIDENTIAL CARE	ROUTE 2 ,BOX 1542 CHECOTAH, OK 74426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS A re-licensure survey was conducted on 08/14/19 and 08/15/19. Current census was 35. The following deficiencies were cited.	R 000		
R 194 SS=E	310:680-1-3 (c) SMOKING PROHIBITED (c) Smoking or possessing a lighted tobacco product is prohibited in a home and within fifteen (15) feet of each entrance to a home and of any air intakes; provided however, the home may provide a smoking room not available to the public for use by residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure cigarette smoking was prohibited in the office. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 08/14/19 at 2:45 p.m., there was a blue haze of smoke and the office smelled strongly of fresh cigarette smoke. The administrator's assistant stated she had been smoking in the office and adjoining room. There was a long white cigarette recently snuffed out in a red ash tray on a table in the adjoining room. At 2:50 p.m., the administrator was interviewed by telephone call stated she had instructed her assistant to go outside to smoke.	R 194		

Oklahoma State Department of Health

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R 317	Continued From page 1	R 317		
R 317 SS=F	310:680-5-3 (d) MAXIMUM TEMPERATURE 85 F (d) Maximum temperature in all areas occupied by residents shall not exceed 85 degrees Fahrenheit, unless authorized or recommended by a physician. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to ensure the dining room temperature did not exceed 85 degrees Fahrenheit (F). This failed practice had the widespread potential for more than minimal harm for all 35 residents who received their meals in the dining room. Findings: On 08/14/19 at 4:35 p.m., the residents gathered for their evening meal and complained about being too hot in the dining room. The ambient air temperature registered at 86.9 degrees F in the middle of the dining room. There were two fans in the back (north end) of the dining room that blew hot air towards the middle of the room. Certified medication aide/employee #2 stated it was hot in the dining room and adjoining medication room, and had been for a while. She further stated it was always hot in the dining room. The residents were then asked what they thought about the temperature in the dining room and they all said it was too hot. Resident #12 stated he was really hot and had to sit in front of one of the fans to be able to eat his food. His face was flushed and he had perspiration on his forehead. At 4:43 p.m., the temperature on the west side of the dining room was 87.1 degrees F. The ambient air temperature outside in the yard by the	R 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 317	Continued From page 2 west dining room door registered at 98.7 degrees F. At 4:54 p.m., the residents standing in line to receive their meals and cook/employee #5 all had beaded perspiration on their foreheads as the evening meal was served. On 08/15/19 at 8:56 a.m., an air conditioning repairman was in the dining room to make repairs. He stated he had been called out to the home on the previous evening due to the high temperatures in the dining room. The repairman also stated the air conditioner had been out on the east side of the building a few days previously. At 4:08 p.m., the administrator stated the home had air conditioning issues and had been hot in the dining room for at least two weeks. She then submitting receipts that documented the air conditioners had not functioned properly in the building that housed the medication room, kitchen, and dining room since 07/19/19.	R 317		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC4601	CROSSROADS RESIDENTIAL CARE

Type of Survey (select all that apply)

2

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 25837	08/14/2019	08/15/2019	0.50	0.00	11.50	0.00	5.00	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

Oklahoma State Department of Health
Creating a State of Health

September 3, 2019

License Number: RC4601
Survey Event ID: 754O11

Ms. Cheri Martin, Administrator
North Fork Residential Care
P.O. Box 1710
Kingston, OK 73439

Dear Ms. Martin:

On **August 15, 2019**, agents from our office completed an 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:

- **R0317:** The proposed action for R0317 is not acceptable due to the completion date is the day before the survey ended. The home did not provide a date of completion to include adequate time to ensure the corrective actions are achieved to prevent further occurrences and compliance is sustained.

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Oklahoma State Department of Health

SD/ldc

Enclosure

Oklahoma State Department of Health

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03202

McAlester Mechanical, L.L.C.

P.O. Box 64
McAlester, Oklahoma, 74502
Tel: (918) 429-6414

DATE	[illegible]
DATE ORDERED	
DATE SCHEDULED	
NAME	[illegible]
PHONE	
ADDRESS	
WORK PHONE	
CITY	[illegible]
STATE	
ZIP	
EMAIL	
JOB LOCATION	

☐ WARRANTY
☐ CONTRACT
☐ SERVICE CONTRACT
☐ NORMAL
☐ RES. ☑ COMM.
☐ ______

MAKE	MODEL	SERIAL NUMBER

DESCRIPTION OF SERVICE WORK	AMOUNT
[illegible]	
[illegible]	
[illegible]	
[illegible]	
[illegible]	
[illegible]	
[illegible]	
[illegible]	
Thank you	

LABOR CHARGE		OVERTIME	
CHARGES 2 HRS. @ [illegible] /HR.=		CHARGES HRS. @ /HR.=	
CHARGES HRS. @ /HR.=		CHARGES HRS. @ /HR =	

TECHNICIAN SIGNATURE | CERTIFICATE NO. | TOTAL OTHER CHARGES

SUBTOTAL	
INSP. CHARGES	
TRIP CHARGE	
TAX	
TOTAL AMOUNT DUE	$85[illegible]

I HEREBY AUTHORIZE THE ABOVE WORK TO BE DONE AS SO ORDERED AND OUTLINED ABOVE. IT IS AGREED THAT THE SELLER WILL RETAIN TITLE TO ANY EQUIPMENT OR MATERIAL FURNISHED UNTIL COMPLETE PAYMENT HAS BEEN MADE. IF SETTLEMENT IS NOT MADE AS AGREED, THE SELLER HAS THE RIGHT TO REMOVE EQUIPMENT AND MATERIAL WITHOUT BEING HELD RESPONSIBLE FOR ANY DAMAGES RESULTING FROM THE REMOVAL OF EQUIPMENT.

AUTHORIZED SIGNATURE

ABOVE ORDERED WORK HAS BEEN COMPLETED AND I ACKNOWLEDGE RECEIPT OF MY COPY.

X [signature] 7/19/19
CUSTOMER SIGNATURE DATE

CHECK LIST	QTY.	ITEM OR PART DESCRIPTION	PRICE	AMOUNT
COMPRESSOR ☐ SUCTION ____ PSI ☐ HEAD ____ PSI ☐ ELECTRICAL CONNECTIONS ☐ CONTACTS TIGHT & CLEAN ☐ OIL LEVEL & CONDITION	1	[illegible]	[illegible]	[illegible]
	1	[illegible]	[illegible]	[illegible]
CONDENSER COIL ☐ CLEAN COIL & CHECK FIN COND. ☐ ENT ____ °F ☐ LVG ____ °F				
REFRIGERANT ☐ LEAK ☐ CHARGE				
FAN AND MOTOR VOLTS ____ AMPS ____ ☐ ELECTRICAL CONNECTIONS ☐ CONTACTS TIGHT & CLEAN ☐ FAN PULLEYS (ADJUST BELT) ☐ CHECK LUG BEARINGS ☐ MOTOR ☐ CFM ____				
EVAPORATOR COIL ☐ CLEAN COIL & CHECK FIN				
CONDENSATE AREAS ☐ INSPECT & CLEAN DRAIN PAN ☐ INSPECT & CLEAN DRAIN				
AIR FILTERS ☐ CLEANED ☐ REPLACED ☐ FILTER SIZE				
HEATING ASSEMBLY ☐ BURNER & HEAT EXCHANGER ☐ FUEL SUPPLY & PRESSURE ☐ PILOT ASSEMBLY ☐ FLAME ADJUSTMENT ☐ PRIMARY RELAY & FLUE ☐ FAN & LIMIT SWITCH OPER ☐ BLOWER ASSEMBLY ☐ RV VALVE ☐ STRIP HEAT ☐ DEFROST CYCLE			TOTAL PARTS	
ELECTRICAL COMP'TS. ☐ RELAYS ☐ CONTACTORS ☐ OVERLOAD ☐ SWITCH				
THERMOSTAT ☐ OK ☐ REPLACE ☐ RELOCATE				

LABOR GUARANTY
The labor charge as recorded here relative to the equipment serviced as noted, is guaranteed for a period of 30 days.

PARTS WARRANTY
All parts as recorded are warranted as per manufacturer specifications.
We do not guaranty any parts, other than those we install. If repairs later become necessary due to other defective parts, they will be charged separately.

TOTAL OTHER CHARGES

TRAVEL TIME
TIME ARRIVED ______
TIME DEPARTED ______
TRAVEL TIME ______

MILEAGE
ENDING ______
START ______
MILES ______
X /HR. =
X /MI. =
TRIP CHARGE $

INSPECTION CHECKLIST

REFRIGERANT
NON USABLE ☐ YES ☐ NO
QTY. ______
DISPOSAL
TYPE REFRIG. ______ QTY ____
RECOVERED? ☐ YES ☐ NO QTY. ____
RECYCLED? ☐ YES ☐ NO QTY ____
RECLAIMED? ☐ YES ☐ NO QTY ____
RETURNED TO THE SYSTEM? ☐ YES ☐ NO QTY ____

EQUIPMENT
CHANGED OUT (OR REPLACED)? ☐ YES ☐ NO
DISMANTLED? ☐ YES ☐ NO
REFRIGERANT DISPOSAL

RECOMMENDED REPAIRS
Insulate Ducts

OWNER'S INITIALS
ACCEPTED
DECLINED

-STATEMENT-

Misty Valley Heat & Air

421975 E. 1155 RD
Eufaula, Oklahoma 74432

OWNER
Johnny Shotwell

(918) 689-7313

NAME: Cross Roads
ADDRESS: P.O Box 466
CITY: Eufaula STATE OK ZIP 74432
LOCATION: West Akumit Med Room

MAKE & MODEL	SERIAL #	DATE
		7-25-19

CASH	C.O.D.	CHARGE	TIME-IN	TIME-OUT
		X		

QUANTITY	DESCRIPTION	PRICE	AMOUNT
1	Stick De Lux Solder		1.85
4½	LB 407C Freon		202.50
	Found, Vacuum Pump		25.00
	Repaired leak on Freon line Where Tem Run Capacitor Blew Hole in Copper Freon line. Purged Nitrogen + Recharged System and Washed Condenser Coil		
		Total Parts	204.35
		Tax	13.28
	2.5HR	Labor	245.00
		TOTAL	487.63

03185

McAlester Mechanical, L.L.C.
P.O. Box 64
McAlester, Oklahoma, 74502
Tel: (918) 429-6414

DATE 11-9
DATE ORDERED
DATE SCHEDULED

NAME
ADDRESS
CITY STATE ZIP
JOB LOCATION
PHONE
WORK PHONE
EMAIL

☐ WARRANTY ☐ CONTRACT ☐ SERVICE CONTRACT ☐ NORMAL ☐ RES ☐ COMM.

MAKE	MODEL	SERIAL NUMBER

CHECK LIST	QTY.	ITEM OR PART DESCRIPTION	PRICE	AMOUNT
COMPRESSOR				
☐ SUCTION ____ PSI				
☐ HEAD ____ PSI				
☐ ELECTRICAL CONNECTIONS				
☐ CONTACTS TIGHT & CLEAN				
☐ OIL LEVEL & CONDITION				
CONDENSER COIL				
☐ CLEAN COIL & CHECK FIN COND.				
☐ ENT ____ °F				
☐ LVG ____ °F				
REFRIGERANT				
☐ LEAK ☐ CHARGE				
FAN AND MOTOR				
VOLTS ____ AMPS ____				
☐ ELECTRICAL CONNECTIONS				
☐ CONTACTS TIGHT & CLEAN				
☐ FAN PULLEYS (ADJUST BELT)				
☐ CHECK LUG BEARINGS				
☐ MOTOR				
☐ CFM ____				
EVAPORATOR COIL				
☐ CLEAN COIL & CHECK FIN				
CONDENSATE AREAS				
☐ INSPECT & CLEAN DRAIN PAN				
☐ INSPECT & CLEAN DRAIN				
AIR FILTERS				
☐ CLEANED				
☐ REPLACED				
☐ FILTER SIZE				
HEATING ASSEMBLY				
☐ BURNER & HEAT EXCHANGER				
☐ FUEL SUPPLY & PRESSURE				
☐ PILOT ASSEMBLY				
☐ FLAME ADJUSTMENT				
☐ PRIMARY RELAY & FLUE				
☐ FAN & LIMIT SWITCH OPER				
☐ BLOWER ASSEMBLY				
☐ RV VALVE				
☐ STRIP HEAT				
☐ DEFROST CYCLE				
ELECTRICAL COMP'TS.				
☐ RELAYS				
☐ CONTACTORS				
☐ OVERLOAD				
☐ SWITCH				
THERMOSTAT				
☐ OK				
☐ REPLACE				
☐ RELOCATE				
		TOTAL PARTS		

LABOR GUARANTY
This labor charge as recorded here relative to the equipment serviced as noted, is guaranteed for a period of 30 days.

PARTS WARRANTY
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We do not guaranty any parts, other than those we install. If repairs later become necessary due to other defective parts, they will be charged separately.

TOTAL OTHER CHARGES

TRAVEL TIME
TIME ARRIVED
TIME DEPARTED
TRAVEL TIME

MILEAGE
ENDING
START
MILES

X /HR. =
X /MI. =
TRIP CHARGE $

INSPECTION CHECKLIST

REFRIGERANT
NON USABLE ☐ YES ☐ NO
QTY.
DISPOSAL
TYPE REFRIG. QTY.
RECOVERED? ☐ YES ☐ NO QTY.
RECYCLED? ☐ YES ☐ NO QTY.
RECLAIMED? ☐ YES ☐ NO QTY.
RETURNED TO THE SYSTEM? ☐ YES ☐ NO QTY.

EQUIPMENT
CHANGED OUT (OR REPLACED)? ☐ YES ☐ NO
DISMANTLED? ☐ YES ☐ NO
REFRIGERANT DISPOSAL

RECOMMENDED REPAIRS

OWNER'S INITIALS
ACCEPTED
DECLINED

DESCRIPTION OF SERVICE WORK — **AMOUNT**

LABOR CHARGE			OVERTIME		
CHARGES	HRS. @	/HR.=	CHARGES	HRS. @	/HR.=
CHARGES	HRS. @	/HR.=	CHARGES	HRS. @	/HR.=

TECHNICIAN SIGNATURE
CERTIFICATE NO.
TOTAL OTHER CHARGES

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AUTHORIZED SIGNATURE

SUBTOTAL	
INSP. CHARGES	
TRIP CHARGE	
TAX	
TOTAL AMOUNT DUE	

ABOVE ORDERED WORK HAS BEEN COMPLETED AND I ACKNOWLEDGE RECEIPT OF MY COPY.
X
PRINTED NAME OF CUSTOMER — DATE

03334

McAlester Mechanical, L.L.C.
P.O. Box 64
McAlester, Oklahoma, 74502
Tel: (918) 429-6414

DATE 8/17/17
DATE ORDERED
DATE SCHEDULED

NAME
ADDRESS
CITY STATE ZIP
PHONE
WORK PHONE
EMAIL
JOB LOCATION

☐ WARRANTY ☐ CONTRACT ☐ SERVICE CONTRACT ☐ NORMAL ☐ RES. ☐ COMM. ☐

MAKE	MODEL	SERIAL NUMBER

CHECK LIST	QTY.	ITEM OR PART DESCRIPTION	PRICE	AMOUNT
COMPRESSOR				
☐ SUCTION ____ PSI				
☐ HEAD ____ PSI				
☐ ELECTRICAL CONNECTIONS				
☐ CONTACTS TIGHT & CLEAN				
☐ OIL LEVEL & CONDITION				
CONDENSER COIL				
☐ CLEAN COIL & CHECK FIN COND.				
☐ ENT ____ °F				
☐ LVG ____ °F				
REFRIGERANT				
☐ LEAK ☐ CHARGE	1	410a 2#		77
FAN AND MOTOR				
VOLTS ____ AMPS ____				
☐ ELECTRICAL CONNECTIONS				
☐ CONTACTS TIGHT & CLEAN				
☐ FAN PULLEYS (ADJUST BELT)				
☐ CHECK LUG BEARINGS				
☐ MOTOR				
☐ CFM ____				
EVAPORATOR COIL				
☐ CLEAN COIL & CHECK FIN				
CONDENSATE AREAS				
☐ INSPECT & CLEAN DRAIN PAN				
☐ INSPECT & CLEAN DRAIN				
AIR FILTERS				
☐ CLEANED				
☐ REPLACED				
☐ FILTER SIZE				
HEATING ASSEMBLY				
☐ BURNER & HEAT EXCHANGER				
☐ FUEL SUPPLY & PRESSURE				
☐ PILOT ASSEMBLY				
☐ FLAME ADJUSTMENT				
☐ PRIMARY RELAY & FLUE				
☐ FAN & LIMIT SWITCH OPER				
☐ BLOWER ASSEMBLY				
☐ RV VALVE				
☐ STRIP HEAT				
☐ DEFROST CYCLE				
		TOTAL PARTS		91
ELECTRICAL COMP'TS.				
☐ RELAYS				
☐ CONTACTORS				
☐ OVERLOAD				
☐ SWITCH				
THERMOSTAT				
☐ OK				
☐ REPLACE				
☐ RELOCATE				

LABOR GUARANTY
The labor charge as recorded here relative to the equipment serviced as noted, is guaranteed for a period of 30 days.

PARTS WARRANTY
All parts as recorded are warranted as per manufacturer specifications.
We do not guaranty any parts, other than those we install. If repairs later become necessary due to other defective parts, they will be charged separately.

TOTAL OTHER CHARGES

TRAVEL TIME
TIME ARRIVED
TIME DEPARTED
TRAVEL TIME

MILEAGE
ENDING
START
MILES
X /HR. =
X /MI. =
TRIP CHARGE $

INSPECTION CHECKLIST

REFRIGERANT
NON USABLE ☐ YES ☐ NO
QTY.
DISPOSAL
TYPE REFRIG. ____ QTY ____
RECOVERED? ☐ YES ☐ NO QTY.
RECYCLED? ☐ YES ☐ NO QTY.
RECLAIMED? ☐ YES ☐ NO QTY
RETURNED TO THE SYSTEM? ☐ YES ☐ NO QTY.

EQUIPMENT
CHANGED OUT (OR REPLACED)? ☐ YES ☐ NO
DISMANTLED? ☐ YES ☐ NO
REFRIGERANT DISPOSAL

RECOMMENDED REPAIRS

OWNER'S INITIALS
ACCEPTED
DECLINED

DESCRIPTION OF SERVICE WORK	AMOUNT
Service Call and labor to change 410a 2# pole Breaker	

LABOR CHARGE			OVERTIME		
CHARGES	HRS. @	/HR.=	CHARGES	HRS. @	/HR.=
CHARGES	HRS. @	/HR.=	CHARGES	HRS. @	/HR.=

TECHNICIAN SIGNATURE ____ CERTIFICATE NO. ____ TOTAL OTHER CHARGES

SUBTOTAL	
INSP. CHARGES	
TRIP CHARGE	
	9.32
TAX	
TOTAL AMOUNT DUE	29.72

I HEREBY AUTHORIZE THE ABOVE WORK TO BE DONE AS SO ORDERED AND OUTLINED ABOVE. IT IS AGREED THAT THE SELLER WILL RETAIN TITLE TO ANY EQUIPMENT OR MATERIAL FURNISHED UNTIL COMPLETE PAYMENT HAS BEEN MADE. IF SETTLEMENT IS NOT MADE AS AGREED, THE SELLER HAS THE RIGHT TO REMOVE EQUIPMENT AND MATERIAL WITHOUT BEING HELD RESPONSIBLE FOR ANY DAMAGES RESULTING FROM THE REMOVAL OF EQUIPMENT.

AUTHORIZED SIGNATURE

ABOVE ORDERED WORK HAS BEEN COMPLETED AND I ACKNOWLEDGE RECEIPT OF MY COPY.

X ____
CUSTOMER SIGNATURE DATE

Oklahoma State Department of Health
Creating a State of Health

September 9, 2019

License Number: RC4601
Survey Event ID: 754O11

Ms. Cheri Martin, Administrator
Crossroads Residential Care
P.O. Box 1710
Kingston, OK 73439

Dear Ms. Martin:

On August 15, 2019, a State Licensure survey was conducted at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 30, 2019**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

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

LC/KS

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC4601	A. BUILDING: _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS RESIDENTIAL CARE	ROUTE 2 ,BOX 1542 CHECOTAH, OK 74426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS A re-licensure survey was conducted on 08/14/19 and 08/15/19. Current census was 35. The following deficiencies were cited.	R 000	RECEIVED SEP - 6 2019 ON THIS DATE Long Term Care	
R 194 SS=E	310:680-1-3 (c) SMOKING PROHIBITED (c) Smoking or possessing a lighted tobacco product is prohibited in a home and within fifteen (15) feet of each entrance to a home and of any air intakes; provided however, the home may provide a smoking room not available to the public for use by residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure cigarette smoking was prohibited in the office. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 08/14/19 at 2:45 p.m., there was a blue haze of smoke and the office smelled strongly of fresh cigarette smoke. The administrator's assistant stated she had been smoking in the office and adjoining room. There was a long white cigarette recently snuffed out in a red ash tray on a table in the adjoining room. At 2:50 p.m., the administrator was interviewed by telephone call stated she had instructed her assistant to go outside to smoke.	R 194	8-30-19 Administrator inserviced staff on where smoking was allowed for staff and residents. Administrator will follow up. 8/30/19	

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

Cheri Carter | administrator | 8-30-19

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC4601	A. BUILDING: _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS RESIDENTIAL CARE	ROUTE 2 ,BOX 1542 CHECOTAH, OK 74426

(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 317	Continued From page 1	R 317		
R 317 SS=F	310:680-5-3 (d) MAXIMUM TEMPERATURE 85 F	R 317		

(d) Maximum temperature in all areas occupied by residents shall not exceed 85 degrees Fahrenheit, unless authorized or recommended by a physician.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, it was determined the home failed to ensure the dining room temperature did not exceed 85 degrees Fahrenheit (F). This failed practice had the widespread potential for more than minimal harm for all 35 residents who received their meals in the dining room. Findings:

On 08/14/19 at 4:35 p.m., the residents gathered for their evening meal and complained about being too hot in the dining room. The ambient air temperature registered at 86.9 degrees F in the middle of the dining room. There were two fans in the back (north end) of the dining room that blew hot air towards the middle of the room. Certified medication aide/employee #2 stated it was hot in the dining room and adjoining medication room, and had been for a while. She further stated it was always hot in the dining room. The residents were then asked what they thought about the temperature in the dining room and they all said it was too hot. Resident #12 stated he was really hot and had to sit in front of one of the fans to be able to eat his food. His face was flushed and he had perspiration on his forehead.

At 4:43 p.m., the temperature on the west side of the dining room was 87.1 degrees F. The ambient air temperature outside in the yard by the

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC4601	A. BUILDING: _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS RESIDENTIAL CARE	ROUTE 2 ,BOX 1542 CHECOTAH, OK 74426

(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 317	Continued From page 2 west dining room door registered at 98.7 degrees F. At 4:54 p.m., the residents standing in line to receive their meals and cook/employee #5 all had beaded perspiration on their foreheads as the evening meal was served. On 08/15/19 at 8:56 a.m., an air conditioning repairman was in the dining room to make repairs. He stated he had been called out to the home on the previous evening due to the high temperatures in the dining room. The repairman also stated the air conditioner had been out on the east side of the building a few days previously. At 4:08 p.m., the administrator stated the home had air conditioning issues and had been hot in the dining room for at least two weeks. She then submitting receipts that documented the air conditioners had not functioned properly in the building that housed the medication room, kitchen, and dining room since 07/19/19.	R 317	 30 CM 8/14/19 The repairs were completed on both air conditioner units. Administrator will follow up. 30 CM 8/14/19	

03202

McAlester Mechanical, L.L.C.

P.O. Box 64
McAlester, Oklahoma, 74502
Tel: (918) 429-6414

DATE	[illegible]
DATE ORDERED	
DATE SCHEDULED	
PHONE	
WORK PHONE	
EMAIL	

NAME [illegible]
ADDRESS
CITY [illegible] STATE ZIP
JOB LOCATION

☐ WARRANTY
☐ CONTRACT
☐ SERVICE CONTRACT
☐ NORMAL
☐ RES. ☑ COMM.
☐ ____

MAKE	MODEL	SERIAL NUMBER

DESCRIPTION OF SERVICE WORK	AMOUNT
[illegible handwriting]	
Thank You	

LABOR CHARGE		OVERTIME	
CHARGES 2 HRS. @ /HR.=		CHARGES HRS. @ /HR.=	
CHARGES HRS. @ /HR.=		CHARGES HRS. @ /HR.=	

TECHNICIAN SIGNATURE — CERTIFICATE NO. — TOTAL OTHER CHARGES

SUBTOTAL	
INSP. CHARGES	
TRIP CHARGE	
TAX	
TOTAL AMOUNT DUE	[illegible]

I HEREBY AUTHORIZE THE ABOVE WORK TO BE DONE AS SO ORDERED AND OUTLINED ABOVE. IT IS AGREED THAT THE SELLER WILL RETAIN TITLE TO ANY EQUIPMENT OR MATERIAL FURNISHED UNTIL COMPLETE PAYMENT HAS BEEN MADE. IF SETTLEMENT IS NOT MADE AS AGREED, THE SELLER HAS THE RIGHT TO REMOVE EQUIPMENT AND MATERIAL WITHOUT BEING HELD RESPONSIBLE FOR ANY DAMAGES RESULTING FROM THE REMOVAL OF EQUIPMENT.

AUTHORIZED SIGNATURE

ABOVE ORDERED WORK HAS BEEN COMPLETED AND I ACKNOWLEDGE RECEIPT OF MY COPY.

X [signature] — 7/[illegible]/[illegible]

CUSTOMER SIGNATURE — DATE

CHECK LIST	QTY.	ITEM OR PART DESCRIPTION	PRICE	AMOUNT
	1	[illegible]	[illegible]	[illegible]
		Repair	1	1
		TOTAL PARTS		

CHECK LIST

COMPRESSOR
- ☐ SUCTION ____ PSI
- ☐ HEAD ____ PSI
- ☐ ELECTRICAL CONNECTIONS
- ☐ CONTACTS TIGHT & CLEAN
- ☐ OIL LEVEL & CONDITION

CONDENSER COIL
- ☐ CLEAN COIL & CHECK FIN COND.
- ☐ ENT ____ °F
- ☐ LVG ____ °F

REFRIGERANT
- ☐ LEAK ☐ CHARGE

FAN AND MOTOR
- VOLTS ____ AMPS ____
- ☐ ELECTRICAL CONNECTIONS
- ☐ CONTACTS TIGHT & CLEAN
- ☐ FAN PULLEYS (ADJUST BELT)
- ☐ CHECK LUG BEARINGS
- ☐ MOTOR
- ☐ CFM ____

EVAPORATOR COIL
- ☐ CLEAN COIL & CHECK FIN

CONDENSATE AREAS
- ☐ INSPECT & CLEAN DRAIN PAN
- ☐ INSPECT & CLEAN DRAIN

AIR FILTERS
- ☐ CLEANED
- ☐ REPLACED
- ☐ FILTER SIZE

HEATING ASSEMBLY
- ☐ BURNER & HEAT EXCHANGER
- ☐ FUEL SUPPLY & PRESSURE
- ☐ PILOT ASSEMBLY
- ☐ FLAME ADJUSTMENT
- ☐ PRIMARY RELAY & FLUE
- ☐ FAN & LIMIT SWITCH OPER
- ☐ BLOWER ASSEMBLY
- ☐ RV VALVE
- ☐ STRIP HEAT
- ☐ DEFROST CYCLE

ELECTRICAL COMP'TS.
- ☐ RELAYS
- ☐ CONTACTORS
- ☐ OVERLOAD
- ☐ SWITCH

THERMOSTAT
- ☐ OK
- ☐ REPLACE
- ☐ RELOCATE

LABOR GUARANTY
The labor charge as recorded here relative to the equipment serviced as noted, is guaranteed for a period of 30 days.

PARTS WARRANTY
All parts as recorded are warranted as per manufacturer specifications.
We do not guaranty any parts, other than those we install. If repairs later become necessary due to other defective parts, they will be charged separately.

TOTAL OTHER CHARGES

TRAVEL TIME
- TIME ARRIVED ____
- TIME DEPARTED ____
- TRAVEL TIME ____

MILEAGE
- ENDING ____
- START ____
- MILES ____
- X /HR. =
- X /MI. =
- TRIP CHARGE $

INSPECTION CHECKLIST

REFRIGERANT
- NON USABLE ☐ YES ☐ NO
- QTY. ____
- DISPOSAL
- TYPE REFRIG. ____ QTY. ____
- RECOVERED? ☐ YES ☐ NO QTY. ____
- RECYCLED? ☐ YES ☐ NO QTY. ____
- RECLAIMED? ☐ YES ☐ NO QTY. ____
- RETURNED TO THE SYSTEM? ☐ YES ☐ NO QTY. ____

EQUIPMENT
- CHANGED OUT (OR REPLACED)? ☐ YES ☐ NO
- DISMANTLED? ☐ YES ☐ NO
- REFRIGERANT DISPOSAL

RECOMMENDED REPAIRS
Insulate Ducts

OWNER'S INITIALS
- ACCEPTED
- DECLINED

-STATEMENT-

Misty Valley Heat & Air

421975 E. 1155 RD
Eufaula, Oklahoma 74432

OWNER
Johnny Shotwell

(918) 689-7313

NAME: Cross Roads
ADDRESS: P.O Box 466
CITY: Eufaula STATE OK ZIP 74432
LOCATION: West Akumit Med Room

MAKE & MODEL	SERIAL #	DATE
		7-25-19

CASH	C.O.D.	CHARGE	TIME-IN	TIME-OUT
		X		

QUANTITY	DESCRIPTION	PRICE	AMOUNT
1	Stick Deluxe Solder		1.85
4 1/2	LB 407C Freon		202.50
	Search, Vacuum Pump		25.00
	Repaired leak on Freon line Where Tem Run Capacitor Blew Hole in Copper Freon line. Rebuilt Vacume + Recharged Systems and Washed Condenser Coil		
		Total Parts	204.35
		Tax	13.28
	2.5HR	Labor	245.00
		TOTAL	487.63

03185

McAlester Mechanical, L.L.C.

P.O. Box 64
McAlester, Oklahoma, 74502
Tel: (918) 429-6414

DATE
DATE ORDERED
DATE SCHEDULED
PHONE
WORK PHONE
EMAIL

NAME
ADDRESS
CITY STATE ZIP
JOB LOCATION

☐ WARRANTY ☐ CONTRACT ☐ SERVICE CONTRACT ☐ NORMAL ☐ RES. ☐ COMM. ☐

MAKE	MODEL	SERIAL NUMBER

CHECK LIST	QTY.	ITEM OR PART DESCRIPTION	PRICE	AMOUNT
COMPRESSOR				
☐ SUCTION ____ PSI				
☐ HEAD ____ PSI				
☐ ELECTRICAL CONNECTIONS				
☐ CONTACTS TIGHT & CLEAN				
☐ OIL LEVEL & CONDITION				
CONDENSER COIL				
☐ CLEAN COIL & CHECK FIN COND.				
☐ ENT ____ °F				
☐ LVG ____ °F				
REFRIGERANT				
☐ LEAK ☐ CHARGE				
FAN AND MOTOR				
VOLTS ____ AMPS ____				
☐ ELECTRICAL CONNECTIONS				
☐ CONTACTS TIGHT & CLEAN				
☐ FAN PULLEYS (ADJUST BELT)				
☐ CHECK LUG BEARINGS				
☐ MOTOR				
☐ CFM ____				
EVAPORATOR COIL				
☐ CLEAN COIL & CHECK FIN				
CONDENSATE AREAS				
☐ INSPECT & CLEAN DRAIN PAN				
☐ INSPECT & CLEAN DRAIN				
AIR FILTERS				
☐ CLEANED				
☐ REPLACED				
☐ FILTER SIZE				
HEATING ASSEMBLY				
☐ BURNER & HEAT EXCHANGER				
☐ FUEL SUPPLY & PRESSURE				
☐ PILOT ASSEMBLY				
☐ FLAME ADJUSTMENT				
☐ PRIMARY RELAY & FLUE				
☐ FAN & LIMIT SWITCH OPER.				
☐ BLOWER ASSEMBLY				
☐ RV VALVE				
☐ STRIP HEAT				
☐ DEFROST CYCLE				
ELECTRICAL COMP'TS.				
☐ RELAYS				
☐ CONTACTORS				
☐ OVERLOAD				
☐ SWITCH				
THERMOSTAT				
☐ OK				
☐ REPLACE				
☐ RELOCATE				
		TOTAL PARTS		

DESCRIPTION OF SERVICE WORK	AMOUNT

LABOR GUARANTY
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PARTS WARRANTY
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TOTAL OTHER CHARGES

LABOR CHARGE			OVERTIME		
CHARGES	HRS. @	/HR.=	CHARGES	HRS. @	/HR.=
CHARGES	HRS. @	/HR.=	CHARGES	HRS. @	/HR.=

TECHNICIAN SIGNATURE
CERTIFICATE NO.
TOTAL OTHER CHARGES

TRAVEL TIME
TIME ARRIVED
TIME DEPARTED
TRAVEL TIME

MILEAGE
ENDING
START
MILES
X /HR. =
X /MI. =
TRIP

INSPECTION CHECKLIST

REFRIGERANT
NON USABLE ☐ YES ☐ NO
QTY.
DISPOSAL
TYPE REFRIG. ____ QTY.
RECOVERED? ☐ YES ☐ NO QTY.
RECYCLED? ☐ YES ☐ NO QTY.
RECLAIMED? ☐ YES ☐ NO QTY.
RETURNED TO THE SYSTEM? ☐ YES ☐ NO QTY.

EQUIPMENT
CHANGED OUT (OR REPLACED)? ☐ YES ☐ NO
DISMANTLED? ☐ YES ☐ NO
REFRIGERANT DISPOSAL

RECOMMENDED REPAIRS

OWNER'S INITIALS
ACCEPTED
DECLINED

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AUTHORIZED SIGNATURE

SUBTOTAL	
INSP. CHARGES	
TRIP CHARGE	
TAX	
TOTAL AMOUNT DUE	

ABOVE ORDERED WORK HAS BEEN COMPLETED AND I ACKNOWLEDGE RECEIPT OF MY COPY.

03334

McAlester Mechanical, L.L.C.

P.O. Box 64
McAlester, Oklahoma, 74502
Tel: (918) 429-6414

DATE 6/14/17
DATE ORDERED
DATE SCHEDULED
NAME
ADDRESS
CITY STATE ZIP
PHONE
WORK PHONE
EMAIL
JOB LOCATION

☐ WARRANTY ☐ CONTRACT ☐ SERVICE CONTRACT ☐ NORMAL ☐ RES. ☐ COMM ☐ ____

MAKE	MODEL	SERIAL NUMBER

CHECK LIST	QTY.	ITEM OR PART DESCRIPTION	PRICE	AMOUNT
COMPRESSOR ☐ SUCTION ____ PSI ☐ HEAD ____ PSI ☐ ELECTRICAL CONNECTIONS ☐ CONTACTS TIGHT & CLEAN ☐ OIL LEVEL & CONDITION				
CONDENSER COIL ☐ CLEAN COIL & CHECK FIN COND. ☐ ENT ____ °F ☐ LVG ____ °F				
REFRIGERANT ☐ LEAK ☐ CHARGE				
FAN AND MOTOR VOLTS ____ AMPS ____ ☐ ELECTRICAL CONNECTIONS ☐ CONTACTS TIGHT & CLEAN ☐ FAN PULLEYS (ADJUST BELT) ☐ CHECK LUG BEARINGS ☐ MOTOR ☐ CFM ____				
EVAPORATOR COIL ☐ CLEAN COIL & CHECK FIN				
CONDENSATE AREAS ☐ INSPECT & CLEAN DRAIN PAN ☐ INSPECT & CLEAN DRAIN				
AIR FILTERS ☐ CLEANED ☐ REPLACED ☐ FILTER SIZE				
HEATING ASSEMBLY ☐ BURNER & HEAT EXCHANGER ☐ FUEL SUPPLY & PRESSURE ☐ PILOT ASSEMBLY ☐ FLAME ADJUSTMENT ☐ PRIMARY RELAY & FLUE ☐ FAN & LIMIT SWITCH OPER. ☐ BLOWER ASSEMBLY ☐ RV VALVE ☐ STRIP HEAT ☐ DEFROST CYCLE				
ELECTRICAL COMP'TS. ☐ RELAYS ☐ CONTACTORS ☐ OVERLOAD ☐ SWITCH				
THERMOSTAT ☐ OK ☐ REPLACE ☐ RELOCATE				
		TOTAL PARTS		

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TOTAL OTHER CHARGES

DESCRIPTION OF SERVICE WORK

AMOUNT

LABOR CHARGE			OVERTIME		
CHARGES	HRS. @	/HR.=	CHARGES	HRS. @	/HR.=
CHARGES	HRS. @	/HR.=	CHARGES	HRS. @	/HR.=

TECHNICIAN SIGNATURE
CERTIFICATE NO.
TOTAL OTHER CHARGES

TRAVEL TIME

TIME ARRIVED
TIME DEPARTED
TRAVEL TIME

MILEAGE

ENDING
START
MILES
X /HR. =
X /MI. =
TRIP

INSPECTION CHECKLIST

REFRIGERANT

NON USABLE ☐ YES ☐ NO
QTY.
DISPOSAL

TYPE REFRIG. ____ QTY. ____
RECOVERED? ☐ YES ☐ NO QTY. ____
RECYCLED? ☐ YES ☐ NO QTY. ____
RECLAIMED? ☐ YES ☐ NO QTY. ____
RETURNED TO THE SYSTEM? ☐ YES ☐ NO QTY. ____

EQUIPMENT

CHANGED OUT (OR REPLACED)? ☐ YES ☐ NO
DISMANTLED? ☐ YES ☐ NO
REFRIGERANT DISPOSAL

RECOMMENDED REPAIRS

OWNER'S INITIALS

ACCEPTED

DECLINED

SUBTOTAL	
INSP. CHARGES	
TRIP CHARGE	
TAX	
TOTAL AMOUNT DUE	217

I HEREBY AUTHORIZE THE ABOVE WORK TO BE DONE AS SO ORDERED AND OUTLINED ABOVE. IT IS AGREED THAT THE SELLER WILL RETAIN TITLE TO ANY EQUIPMENT OR MATERIAL FURNISHED UNTIL COMPLETE PAYMENT HAS BEEN MADE. IF SETTLEMENT IS NOT MADE AS AGREED, THE SELLER HAS THE RIGHT TO REMOVE EQUIPMENT AND MATERIAL WITHOUT BEING HELD RESPONSIBLE FOR ANY DAMAGES RESULTING FROM THE REMOVAL OF EQUIPMENT.

AUTHORIZED SIGNATURE

ABOVE ORDERED WORK HAS BEEN COMPLETED AND I ACKNOWLEDGE RECEIPT OF MY COPY

Oklahoma State Department of Health
Creating a State of Health

December 12, 2019

License Number: RC4601
Survey Event ID: 754O12

Ms. Cheri Martin, Administrator
Crossroads Residential Care
Route 2 ,box 1542
Checotah, OK 74426

Dear Ms. Martin:

On **October 14, 2019**, a revisit was conducted at 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 on **August 15, 2019,** have now been corrected and your facility is in compliance with licensure standards effective **August 30, 2019**.

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC4601	A. BUILDING: _____ B. WING _____	R 10/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS RESIDENTIAL CARE	ROUTE 2 ,BOX 1542 CHECOTAH, OK 74426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS A follow-up survey was conducted on 10/14/19. Current census was 37. Both deficiencies were cleared.	{R 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC4601	CROSSROADS RESIDENTIAL CARE

Type of Survey (select all that apply)

2	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 25837	10/14/2019	10/14/2019	0.50	0.00	1.50	0.00	2.50	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**