OKLAHOMA
State Department of Health

Delivery via email to: northfork@treatmentservices.org

April 10, 2023

License Number: RC4601
Survey Event ID: XZHX11

Ms. Shawna Phillips, Administrator
North Fork Residential Care
P.O. Box 1710
Kingston, OK 73439

Dear Ms. Phillips:

Enclosed is a report of the complaint investigation conducted at your Residential Care facility on **April 3, 2023**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Crossroads Residential Care**
Address: **Route 2, Box 1542**
City, State, Zip: **Checotah, OK, 74426**
Provider #: **RC4601**
Complaint #: **OK00060328**
Investigation Date(s): **03/31/23 and 04/03/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to assess, monitor, and intervene for a resident in distress.	**US**
2. The home failed to administer medications according to physician's orders.	**US**
3. The home failed to provide a 30-day notice and failed to ensure residents were not involuntarily discharged.	**US**

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

An unannounced on-site investigation was initiated on 03/31/2023 at 10:45 a.m.

A sample of five residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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 unsubstantiated related to this allegation.

An investigation specific to assessment, monitoring, and intervening for a resident in distress was conducted.

On entry and throughout the survey, residents were observed ambulating throughout the home, in the indoor common area, outdoor areas, around buildings, and in the hall by the medication room. No residents appeared

to have been in distress. Staff members were observed speaking with residents and interacting with them in a calm and respectful manner. The staff members were observed to be attentive to resident needs and responded accordingly.

Residents were interviewed and reported they were satisfied with the care they received from the home. Staff members were interviewed and reported they assessed residents quickly if they received a report the resident was experiencing distress and moved them to a room in the front building where observations could be obtained in a quicker manner.

Resident records including, physician order, medication administration records, hospital records, incident reports, progress notes, and other documentation was reviewed. Incident reports were reviewed.

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

An investigation specific to the administration of physician ordered medications was conducted.

On entry and throughout the survey, residents were observed ambulating throughout the home, in the indoor common area, outdoor areas, around buildings, and in the hall by the medication room. No residents appeared to have been in distress. Staff members were observed speaking with residents and interacting with them in a calm and respectful manner. The staff members were observed to be attentive to resident needs and responded accordingly.

Residents were interviewed and reported they were satisfied with the care they received from the home. The residents did not voice concerns regarding their medications. The staff members stated some residents had pocketed medications or regurgitated them after being dispensed by staff. The staff members stated they observed the residents take the medications and, for those who had a history of pocketing or regurgitating medications, they were required to sit near the medication window for 30 minutes after dispensing the medications.

Resident records including, physician order, medication administration records, hospital records, incident reports, progress notes, and other documentation was reviewed. Incident reports were reviewed.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.
An investigation specific to involuntary discharge was conducted.

Staff members were interviewed and stated the home was only required to provide a 10 day notice per state regulation. The staff members stated the residents signed a form on admission whereby they stated they understood they would be immediately discharged if they threated or posed a danger to other residents or staff. The home stated on discharge the resident would be taken to a local shelter. The staff member stated the named resident was expected to return to the home but was admitted to another home. The staff member stated the home discharged the resident after the family retrieved the resident's personal belongings and informed them he would not be returning as they had been admitted to another home.

Resident records were reviewed including progress notes, which documented resident's family members had retrieved their belongings, and medication reconciliation records, which documented the resident's family member had signed they received their loved one's medications. Business office records were reviewed and revealed a refund was due to the resident and a family member was to pick the money up.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1, 2, and #3. 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.

G. Rose Dosch RN.

G. Rose Dosch, RN

Date report completed: 04/04/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC4601	A. BUILDING: _____ B. WING _____	C 04/03/2023

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 complaint investigation (OK00060328) was conducted on 03/31/23 and 04/03/23. No deficiencies were cited.	R 000		

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