
Delivery via email to: northfork@treatmentservices.org

August 16, 2023

License Number: RC4601
Survey Event ID: S9JC11

Ms. Margaret Patty, Administrator,
Crossroads Residential Care
P.O. Box 1710
Kingston, OK 73439

Dear Ms. Patty:

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 **July 18, 2023**.

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.

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT

Facility: Crossroads Residential Care
Address: Route 2 Box 1542
City, State, Zip: Checotah, OK 74426
Provider #: RC4601
Complaint #: 00060960
Investigation Date(s): 07/17/2023

ALLEGATION(S)

The facility failed to provide adequate supplies to ensure an effective pest control program.

The facility failed to provide access to forms of communication .

An unannounced on-site investigation was initiated 07/17/2023 at 5:05 A.M.

A sample of 3 residents, including any identified residents, 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey.

Resident records were reviewed including nursing notes, progress notes, care plans, ADL Logs.

Facility Pest control records were reviewed.

Rooms did not currently have any bed bugs or pests.

Pest control company, residents and staff were interviewed and pest control services were all documented and accounted for.

Residents were able to have access to phone and forms of communication as well.

The attached Statement of Deficiencies, Form 2567 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: 07/18/2023

INVESTIGATIVE REPORT

Facility: Crossroads Residential Care
Address: Route 2 box 1542 Checotah, OK
City, State, Zip: Checotah, OK 74426
Provider #: RC4601
Complaint #: 00060974
Investigation Date(s): 07/14/23 – 07/18/23

ALLEGATION(S)

The home failed to assess, monitor and intervene in an effort to prevent new/worsening wounds

An unannounced on-site investigation was initiated 07/14/2023 at 3:40 P.M.

A sample of 3 residents, including any identified residents, 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey.

Resident records were reviewed including nursing notes, care plans, progress notes, quarterly reviews.

Interviews were conducted and the Admin Assistant was the only employee who is currently working at the facility that was an employee at the time. She stated as soon as they saw the resident's foot he was admitted (07/03/23) to the hospital (Saint Francis Muskogee) the same day. I called the long term acute care facility he is currently at (Cornerstone Muskogee) and his case manager stated he is doing better every day. I asked if I could interview him and he declined. Interviews were conducted with residents and staff regarding the provision of and assistance with activities of daily living to residents in a timely manner.

The attached Statement of Deficiencies, Form 2567 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: 07/18/2023



INVESTIGATIVE REPORT

Facility: Crossroads Residential Care
Address: Route 2 Box 1542 Checotah, Ok
City, State, Zip: Checotah, OK 74426
Provider #: RC6401
Complaint #: OK00060984
Investigation Date(s): 07/17/23 - 07/18/23

ALLEGATION(S)

The home failed to maintain working air conditioning systems.

The home failed to ensure residents were not involuntarily isolated.
--

An unannounced on-site investigation was initiated 07/14/2023 at 3:40 P.M.

A sample of 3 residents, including any identified residents, 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident rooms were observed for potential air conditioning units not working within resident rooms. On July 17 there were three resident rooms with a bad a/c unit that was not properly working (room 11, 18, & 26) the new administrator acknowledged and stated they will be fixed and or replaced immediately.

The A/C unit within the kitchen and dining area were fixed before noon on July 17 while I was at the facility. The residents interviewed in these rooms did not claim to be hot but it was a cloudy day. I interviewed staff and I also looked at recent temperature checks in each room that the administrator was documenting and seem to be very proactive in accommodating to residents needs and also getting the individual units fixed.

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident rooms were observed at 5:05 AM July 17 for potential doors being locked at night while the residents were in their rooms sleeping.

I interviewed residents and was stated they have not been locked in rooms and upon checking doors at 5:05 AM the resident doors cannot be locked from the outside.

The attached Statement of Deficiencies, Form 2567 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: 07/18/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 07/14/2023 through 07/18/2023 Complaint investigations (#OK00060984, OK00060960, and OK00060974).	R 000		
R 225 SS=F	310:680-3-6 (e) EVACUATION PLAN AND FIRE DRILLS (e) An evacuation plan shall be developed and permanently displayed in the hallways and sitting room. Fire drills shall be conducted at least quarterly. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure fire drills were conducted at least quarterly. The census was 48 residents. Findings: On 07/17/23 The only fire drill that was provided that was documented was on May 26, 2023 On 07/17/23 At 10:15 a.m., From July 2022 to July 2023 the administrator acknowgdged May 26, 2023 was the only fire drill they were able to provide but she will make sure to conduct a fire drill for each quarter moving forward.	R 225		
R 315 SS=D	310:680-5-3 (b) AIR CONDITIONING (b) Refrigerated air conditioning shall be provided to each resident's room. Refrigerated air conditioning units and vents shall be kept clean and in good repair.	R 315		

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: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	Continued From page 1 This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to provide air conditioning units and vents shall be kept clean and in good repair. This had potential for more than minimal harm for all 6 residents. Findings: On 07/17/23 at 1:00 p.m., a tour of the home was conducted and the air conditioning unit in room 11 would not blow cold air to provide air conditioning to the residents. On 07/17/23 at 1:55 p.m., a tour of the home was conducted and air conditioning units in room 18 and 26 were not able to be turned on to operate and provide air conditioning to the residents. Residents stated to be "hot sometimes". On 07/17/23 at 2:00 p.m., the administrator further stated she agreed these specific air conditioning units were not blowing cold and or not able to be turned on and the rooms were hot. The administrator stated she would have them be fixed or replaced immediately while also doing daily temperature checks in rooms.	R 315		
R 334 SS=E	310:680-5-7 (a) RESIDENT ROOMS - ACCOMMODATIONS (a) Each resident shall be provided with clean, comfortable orderly, and reasonable private living accommodations.	R 334		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 334	Continued From page 2 This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure that each resident shall be provided with clean, comfortable, orderly, and reasonably private living accommodations. The administrator identified 48 residents resided in the home. Findings: Based on observation and interview, the facility failed to ensure resident rooms were clean and orderly for seven of seven sampled resident rooms. This had the widespread potential for more than minimal harm for all 4 residents. Findings: On 07/17/23, a tour of the facility showed the following: Room #15 had clothes and shoes on the floor and under the bed, Room # 16 had clothes and shoes on the floor and under the bed, Room # 21 had clothes and shoes on the floor and under the bed, On 06/26/23 at 2:00 p.m., The Administrator stated, "We try to remind the clients to clean their room but we will get them cleaned and organized."	R 334		
R 345 SS=E	310:680-5-7(I) RESIDENT ROOMS - MATTRESS/BED LINENS	R 345		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 3 (I) Each resident's bed shall have a comfortable mattress and bed linens which are clean and in good condition. This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure pillows, bed linens, and mattresses were comfortable, clean, and in good repair. (Room 15, 16, and 21) This had the potential for more than minimal harm for all 4 residents. The administrator identified 48 residents resided in the home. Findings: On 07/17/23 at 1:30 p.m., resident rooms were observed. Room 15 bed was observed and had dirty sheets on mattress. Room 16 bed was observed and had dirty sheets on mattress. Room 21 bed was observed and had dirty sheets on mattress . On 07/17/22 at 2:10 p.m., the administrator ackwnolowdged the dirty sheets and she stated she would make sure the sheets would be cleaned and replaced.	R 345		
R 357 SS=E	310:680-7-5 (b) HOUSEKEEPING	R 357		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 357	Continued From page 4 (b) Practices and procedures shall be utilized to keep the home free from offensive odors, accumulation of dirt, rubbish, dust, and safety hazards. This Rule is not met as evidenced by: Based on observation, record review, and interview it was determined the home failed be free from offensive odors. This had the potential for more than minimal harm for all 4 residents. Findings: On 07/17/23 at 1:26 p.m. Resdient room #15 had a foul odor and dirt/mud on the floor around the bed. On 07/17/23 at 1:30 p.m. Resdient room #16 had a foul odor and dirt/mud on the floor around the bed. On 07/17/23 at 1:40 p.m. Resdient room #21 had a foul odor and dirt/mud on the floor around the bed. On 07/17/23 at 2:00 p.m. The administrator acknowldged the bad odors along with the dirt and mud on the floors around the bed and she stated she would make sure they would get cleaned and organized.	R 357		

Delivery via email to: northfork@treatmentservices.org

September 18, 2023

License Number: RC4601

Survey Event ID: S9JC11

Ms. Margaret Patty, Administrator
Crossroads Residential Care
P.O. Box 1710
Kingston, OK 73439

Dear Ms. Patty:

On **July 18, 2023**, a Complaint investigation and a Relicensure survey were 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 have been corrected and you were in substantial compliance by **August 26, 2023**.

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,



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

enc

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 07/14/2023 through 07/18/2023 Complaint investigations (#OK00060984, OK00060960, and OK00060974).	R 000		
R 225 SS=F	310:680-3-6 (e) EVACUATION PLAN AND FIRE DRILLS (e) An evacuation plan shall be developed and permanently displayed in the hallways and sitting room. Fire drills shall be conducted at least quarterly. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure fire drills were conducted at least quarterly. The census was 48 residents. Findings: On 07/17/23 The only fire drill that was provided that was documented was on May 26, 2023 On 07/17/23 At 10:15 a.m., From July 2022 to July 2023 the administrator acknowledged May 26, 2023 was the only fire drill they were able to provide but she will make sure to conduct a fire drill for each quarter moving forward.	R 225	By 8-26-23 Evacuation Plans & fire drills are being done quarterly. By staff Administrator will follow up	8-24-23
R 315 SS=D	310:680-5-3 (b) AIR CONDITIONING (b) Refrigerated air conditioning shall be provided to each resident's room. Refrigerated air conditioning units and vents shall be kept clean and in good repair.	R 315	By 8-18-23 Checking Room temps & cleaning/repairing units as needed By staff and maintenance Administrator will follow up	

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

Maryann Pugh

TITLE

Administrator

(X6) DATE

9-18-23

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	Continued From page 1 This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to provide air conditioning units and vents shall be kept clean and in good repair. This had potential for more than minimal harm for all 6 residents. Findings: On 07/17/23 at 1:00 p.m., a tour of the home was conducted and the air conditioning unit in room 11 would not blow cold air to provide air conditioning to the residents. On 07/17/23 at 1:55 p.m., a tour of the home was conducted and air conditioning units in room 18 and 26 were not able to be turned on to operate and provide air conditioning to the residents. Residents stated to be "hot sometimes". On 07/17/23 at 2:00 p.m., the administrator further stated she agreed these specific air conditioning units were not blowing cold and or not able to be turned on and the rooms were hot. The administrator stated she would have them be fixed or replaced immediately while also doing daily temperature checks in rooms.	R 315	By 8-18-23 Air Temp Checks by staff being done, Cleaning and repairing A/C's as needed, Replacement if necessary. by Maintenance. Follow up by Administrator	7-18-23 ongoing
R 334 SS=E	310:680-5-7 (a) RESIDENT ROOMS - ACCOMMODATIONS (a) Each resident shall be provided with clean, comfortable orderly, and reasonable private living accommodations.	R 334	By 8-18-23 House Keeping will be checking rooms, encouraging residents to clean rooms. House Keeping cleaning rooms when needed Administrator will follow-up	7-22-23

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 334	Continued From page 2 This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure that each resident shall be provided with clean, comfortable, orderly, and reasonably private living accommodations. The administrator identified 48 residents resided in the home. Findings: Based on observation and interview, the facility failed to ensure resident rooms were clean and orderly for seven of seven sampled resident rooms. This had the widespread potential for more than minimal harm for all 4 residents. Findings: On 07/17/23, a tour of the facility showed the following: Room #15 had clothes and shoes on the floor and under the bed, Room # 16 had clothes and shoes on the floor and under the bed, Room # 21 had clothes and shoes on the floor and under the bed, On 06/26/23 at 2:00 p.m., The Administrator stated, "We try to remind the clients to clean their room but we will get them cleaned and organized."	R 334	<i>By 8-18-23</i> <i>staff / Housekeeping</i> <i>checking rooms, encouraging residents</i> <i>to clean their rooms, Housekeeping</i> <i>Cleaning as needed.</i> <i>Administrator will follow-up</i> <i>with periodic checks</i>	
R 345 SS=E	310:680-5-7(I) RESIDENT ROOMS - MATTRESS/BED LINENS	R 345		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 345	Continued From page 3 (I) Each resident's bed shall have a comfortable mattress and bed linens which are clean and in good condition. This Rule is not met as evidenced by: Based on observation and interview, the home failed to ensure pillows, bed linens, and mattresses were comfortable, clean, and in good repair. (Room 15, 16, and 21) This had the potential for more than minimal harm for all 4 residents. The administrator identified 48 residents resided in the home. Findings: On 07/17/23 at 1:30 p.m., resident rooms were observed. Room 15 bed was observed and had dirty sheets on mattress. Room 16 bed was observed and had dirty sheets on mattress. Room 21 bed was observed and had dirty sheets on mattress. On 07/17/22 at 2:10 p.m., the administrator acknowledged the dirty sheets and she stated she would make sure the sheets would be cleaned and replaced.	R 345	<i>By 8-18-23</i> <i>Housekeeping</i> <i>Replacing stained/dirty</i> <i>Sheets. Encouraging residents</i> <i>to keep dirty sheets off Beds</i> <i>shoes</i> <i>Inservue conducted 8-28-23</i> <i>on Job Duties.</i> <i>Replacing mattresses as needed</i> <i>Administrator will follow</i> <i>up to ensure it's being</i> <i>done.</i>		
R 357 SS=E	310:680-7-5 (b) HOUSEKEEPING	R 357			8-21-23

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/18/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 357	Continued From page 4 (b) Practices and procedures shall be utilized to keep the home free from offensive odors, accumulation of dirt, rubbish, dust, and safety hazards. This Rule is not met as evidenced by: Based on observation, record review, and interview it was determined the home failed be free from offensive odors. This had the potential for more than minimal harm for all 4 residents. Findings: On 07/17/23 at 1:26 p.m. Resident room #15 had a foul odor and dirt/mud on the floor around the bed. On 07/17/23 at 1:30 p.m. Resident room #16 had a foul odor and dirt/mud on the floor around the bed. On 07/17/23 at 1:40 p.m. Resident room #21 had a foul odor and dirt/mud on the floor around the bed. On 07/17/23 at 2:00 p.m. The administrator acknowldged the bad odors along with the dirt and mud on the floors around the bed and she stated she would make sure they would get cleaned and organized.	R 357	<i>By 08-18-23</i> <i>staff checking rooms, encouraging residents to clean their rooms</i> <i>Housekeeping cleaning as needed</i> <i>En service conducted 8-28-23 8-28-23</i> <i>for job duties</i> <i>Administrator will do</i> <i>Periodic Checks to ensure it's being done</i> <i>8-21-23</i>	

In Service Meeting

FACILITY: CrossroadsTRAINING TOPIC: Time Sheets, Job Duties, Incident Reporting, theftNUMBER OF HOURS: 2~~000~~ 1INSTRUCTOR: Aug. 28th 2023 Margaret, Bree,EMPLOYEE NAME
(PLEASE PRINT)Zach Mordausch
Deloris Simmons
Schane Green
Landon WhitlockTERRY DILLON
Leah Ledford
PATRICIA MORRIS
Richard White
Amanda Hale
Dreyon JamesEMPLOYEE NAME
(PLEASE SIGN)Zach Mordausch
Deloris Simmons
Schane Green
Landon Whitlock
Terry Dillon
Leah Ledford
Patricia Morris
Richard White
Amanda Hale
Dreyon James

I certify the above individuals participated in our facility in house training as required by OS-1-836.

Margaret Bree
8/28/2023

Administrator

Date

7-15-23

Rm Not in use.

AC temp check list Date: 7-15-23 Temp outside: 87.1				AC temp check list Date: 7-18-23 Temp outside: 91.2				AC temp check list Date: 7-20-23 Temp outside: 95.4			
Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp
Bungo A	X	66	68.9	Bungo A	X	66	68.7	Bungo A	X	69	69.7
Bungo B				Bungo B				Bungo B			
1	X	60.2	67.5	1	X	65	68.5	1	X	65	68.3
2	X	70	77.9	2	X	76	74.6	2	X	76	74.4
3	X	65	70.5	3				3			
4	X	67	77.5	4	X	67	72.2	4	X	67	72.3
5	X	65	69.3	5	X	65	69.7	5	X	65	69.9
6	X	65	73.8	6	X	65	71.3	6	X	65	69.8
7	X	70	75	7	X	70	74.9	7	X	76	75.1
8	X	66	73.3	8	X	67	73.6	8	X	67	73.8
9	X	68	79.3	9	X	69	76.2	9	X	69	77.1
10	X	65	73.8	10	X	65	72.9	10	X	65	72.8
11	X	70	71.1	11	X	70	72	11	X	70	72
12	X	79	82.4	12	X	75	79.6	12	X	75	79.8
13	X	66	71.4	13	X	65	71	13	X	65	70.2
14	X	71	76.5	14	X	70	75.2	14	X	70	73.6
15	X	61	83.5	15	X	65	78.9	15	X	65	78.1
16	X	75	78.3	16	X	75	78.6	16	X	75	78.3
17	X	62	73.3	17				17			
18	X	72	84.2	18	X	72	84.5	18	X	69	74.1
19	X	61	75.0	19	X	61	74.4	19	X	64	70.7
20	X	61	73.8	20	X	62	73.4	20	X	65	72.4
21	X	70	71.1	21	X	70	71.6	21	X	70	71.3
22	X	62	71.6	22	X	62	70.4	22	X	62	69.9
23	X	69	72.9	23	X	69	72.9	23	X	67	71.4
24	X	68	74.8	24	X	69	74.9	24	X	69	74.2
25	X	65	70.9	25	X	65	70.9	25	X	65	70.9
26	X	61	83.8	26	X	65	84.9	26	X	65	71.1

cleaned AC

cleaned

AC Fixed

Replaced AC

Replaced AC

Replaced AC

cleaned

RA Not in use

AC temp check list Date: 7.24.23 Temp outside: 95.3				AC temp check list Date: 7.26.23 Temp outside: 97.8				AC temp check list Date: 7.28.23 Temp outside: 98.8			
Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp
Bungo A	X	60.7	68.9	Bungo A	X	65.0	79.8	Bungo A	X	60.6	68.3
Bungo B				Bungo B				Bungo B			
1	X	65	68.3	1			79.8	1	X	65	68.9
2	X	70	70.2	2	X	69	74.1	2	X	65	68.3
3				3				3			
4	X	67	72.1	4	X	65	72.6	4	X	65	72.9
5	X	65	69.7	5	X	67	70.2	5	X	65	69.9
6	X	65	69.5	6	X	65	69.9	6	X	65	69.9
7	X	70	74.8	7	X	70	75.4	7	X	70	75.9
8	X	67	73.1	8	X	67	74.1	8	X	67	74.4
9	X	69	75.4	9	X	68	77.2	9	X	65	71.5
10	X	65	72.7	10	X	65	73.1	10	X	65	73.3
11	X	70	71.9	11	X	69	71.6	11	X	67	71.1
12	X	74	77.8	12	X	75	79.9	12	X	73	77.4
13	X	65	69.9	13			80.4	13	X	65	70.1
14	X	70	73.2	14	X	71	74.2	14	X	67	70.4
15	X	65	72.9	15	X	65	71.1	15	X	60.6	71.9
16	X	77	78.7	16	X	75	78.4	16	X	75	79.1
17				17				17			
18	X	64	74.2	18	X	68	72.4	18	X	68	73.1
19	X	65	70.9	19	X	64	71.7	19	X	65	72.2
20	X	65	72.3	20	X	65	72.4	20	X	65	72.6
21	X	70	71.1	21	X	70	71.9	21	X	70	72.1
22	X	62	69.6	22	X	62	69.9	22	X	62	69.9
23	X	67	72.1	23	X	68	73.2	23	X	66	70.2
24	X	69	73.5	24	X	67	71.7	24	X	65	71.1
25	X	65	70.2	25	X	65	70.4	25	X	65	70.6
26	X	65	71.5	26	X	65	71.9	26	X		89.9

AC Freezer
turned off

AC Freezer
turned off

AC Freezer
turned off

AC Freezer
turned off

RM Not in Use

AC temp check list Date: 7/31/23 Temp outside: 110.10				AC temp check list Date: 8/3/23 Temp outside: 107.2				AC temp check list Date: 8/7/23 Temp outside: 88.1			
Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp
Bungo A	X	66	70.1	Bungo A	X	65	73.3	Bungo A	X	66	67.2
Bungo B				Bungo B				Bungo B			
1	X	65	69.4	1	X	65	71.3	1	X	65	67.1
2	X	69	74	2	X	65	74.6	2	X	70	76.5
3				3				3			
4	X	65	70.1	4	X	65	72.1	4	X	65	70.1
5	X	65	69.7	5	X	65	70.2	5	X	65	69.6
6	X	65	70.2	6	X	65	72.1	6	X	65	70.1
7	X	67	74.2	7	X	65	74.3	7	X	70	73.2
8	X	65	73.9	8	X	65	74.1	8	X	67	72.6
9	X	65	74.4	9	X	65	74.4	9	X	69	70.4
10	X	65	73.7	10	X	65	73.9	10	X	65	69.8
11	X	69	72.9	11	X	69	74.1	11	X	70	71.6
12	X	73	79.1	12	X	70	79.8	12	X	75	79.5
13	X	65	71.1	13	X	65	73.5	13	X	65	69.8
14	X	70	74.4	14	X	70	77.6	14	X	70	74.1
15	X	65	75.5	15	X	65	76.4	15	X	65	71.1
16	X	70	75.4	16	X	70	77.4	16	X	75	78.5
17				17				17			
18	X	70	74.2	18	X	70	77.9	18	X	70	73.4
19	X	65	72.4	19	X	65	74.5	19	X	69	75.1
20	X	65	72.9	20	X	65	74.9	20	X	65	69.8
21	X	70	73.6	21	X	65	73.2	21	X	70	71.6
22	X	65	69.8	22	X	65	70.1	22	X	62	68.5
23	X	65	72.2	23	X	67	74.3	23	X	69	71.5
24	X	65	72.5	24	X	65	73.9	24	X	66	69.8
25	X	65	73.1	25	X	65	75.1	25	X	65	68.9
26	X	65	72.6	26	X	65	73.9	26	X	65	70.1

closed door

checked

Run Not in Use

AC temp check list Date: 8/10/23 Temp outside: 92.7				AC temp check list Date: 8/14/23 Temp outside: 84.3				AC temp check list Date: 8/17/23 Temp outside: 94.9			
Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp
Bungo A	X	67	69.1	Bungo A	X	69	69.9	Bungo A	X	65	68.1
Bungo B				Bungo B				Bungo B			
1	X	66	68.4	1	off	76	76.4	1	X	65	68.3
2	X	70	74.1	2			74.9	2	X	70	74.1
3				3				3			
4	X	66	71.1	4	off	78.3	turned on	4	X	65	69.8
5	X	65	66.9	5	X	67	76.2	5	X	65	68.9
6	X	65	69.1	6	X	67	70.4	6	X	65	68.8
7	X	70	73.9	7	X	70	74.1	7	X	70	74.6
8	X	66	70.2	8	X	67	72.5	8	X	65	70.1
9	X	67	72.1	9	X	69	71.1	9	X	67	69.9
10	X	65	70.6	10	X	65	69.9	10	X	65	70.2
11	X	70	73.2	11	X	70	72.1	11	X	70	73.1
12	X	74	77.4	12	X	75	78.9	12	X	75	79.9
13	X	65	71.1	13	X	65	69.2	13	X	65	69.2
14	X	70	74.6	14	X	70	72.9	14	X	70	73.9
15	X	65	70.2	15	X	65	70.6	15	X	65	69.6
16	X	73	77.4	16	X	75	77.9	16	X	73	76.9
17				17				17			
18	X	70	75.1	18	X	70	73.1	18	X	65	70.1
19	X	66	70.2	19	X	67	71.1	19	X	67	70.6
20	X	64	76.1	20	X	65	67.9	20	X	65	70.3
21	X	70	72.0	21	off	78.4	turned on	21	X	70	72.1
22	X	65	69.8	22	X	62	68.0	22	X	65	69.3
23	X	67	71.6	23	X	67	70.1	23	X	65	68.2
24	X	69	73.9	24	X	69	70.1	24	X	66	70.2
25	X	65	69.6	25	X	65	68.8	25	X	65	70.3
26	X	65	72.1	26	off	77.6	turned on	26	X	65	70.9

Rm Action Use

AC temp check list Date: 8-11-23 Temp outside: 101.5				AC temp check list Date: 8-22-23 Temp outside: 98.6				AC temp check list Date: 8-24-23 Temp outside: 101.0			
Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp
Bungo A	X	60.5		Bungo A	X	60.4	68	Bungo A	X	66.0	68.9
Bungo B				Bungo B				Bungo B			
1	X	60.5	69.2	1	off	60.5	81.9	1	X	60.6	69.1
2	X	60.8	74.2	2			69.1	2	X	60.6	76.2
3				3				3			
4	X	60.5	70.2	4	off	60.5	84.0	4	X	60.5	69.8
5	X	60.5	69.9	5	X	60.5	72.9	5	X	60.5	69.7
6	X	60.7	71.1	6	X	60.5	72.0	6	X	60.5	70.1
7	X	60.5	73.1	7	X	60.9	77.9	7	X	60.6	71.2
8	X	60.5	73.4	8	X	60.9	75.4	8	X	60.7	71.9
9	X	60.5	71.2	9	X	60.5	80.7	9	X	60.5	70.1
10	X	60.7	73.6	10	X	60.1	80.0	10	X	60.5	71.4
11	X	60.0	74.6	11	X	60.0	81.7	11	off	70.0	84.6
12	X	60.5	69.3	12	X	60.0	73.6	12	X	60.5	69.2
13	X	60.0	73.9	13	X	60.2	75.0	13	X	60.5	74.1
14	X	60.5	69.6	14	off	60.5	84.9	14	X	60.5	69.3
15	X	60.9	73.6	15	X	60.8	88.5	15	off	70.0	79.4
16	X	70.0	74.6	16	X	60.7	72.7	16	X	70.0	74.2
17				17				17			
18	X	60.7	72.6	18	X	72	80.8	18	X	60.5	71.1
19	X	60.5	70.2	19	X	72	74.7	19	X	60.5	70.9
20	X	60.5	72.10	20	X	75	81.0	20	X	60.5	71.0
21	X	60.7	71.4	21	X	60.8	71.2	21	X	60.6	76.9
22	X	60.5	60.6.9	22	X	60.0	76.3	22	X	60.5	69.9
23	X	60.5	70.7	23	X	60.9	74.7	23	X	60.5	70.1
24	X	60.6	71.9	24	X	60.1	70.7	24	X	60.7	72.1
25	X	60.5	70.2	25	off	60.0	76.1	25	X	60.6	70.6
26	X	60.8	71.9	26	X	60.0	76.5	26	X	60.5	69.9

Turned on AC

Turned on AC

Turned on AC

Turned on AC

Turned on AC

Turned on AC

Turned on AC

2M Action 45

AC temp check list Date: 8-28-23 Temp outside: 96.8				AC temp check list Date: 8-31-23 Temp outside: 92.7				AC temp check list Date: 9-4-23 Temp outside: 98.2			
Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp
Bungo A	X	66.6	68.8	Bungo A	X	65	68.1	Bungo A	X	65	67.9
Bungo B				Bungo B				Bungo B			
1	X	66.6	68.3	1	X	65	67.9	1	X	65	68.1
2	X	65	69.2	2	X	70	74.3	2	X	70	74.2
3				3				3			
4	X	65	69.9	4	X	65	71.4	4	X	65	70.1
5	X	65	71.4	5	X	65	67.8	5	X	65	69.6
6	X	65	68.9	6	X	65	68.6	6	X	65	69.3
7	X	64	69.2	7	X	71	74.7	7	X	70	74.2
8	X	67	70.1	8	X	65	69.6	8	X	65	69.9
9	X	65	69.6	9	X	66	69.9	9	X	67	72.1
10	X	65	69.8	10	X	65	70.2	10	X	65	69.6
11	X	70	72.2	11	off		80.1	11	X	70	72.4
12	X	68	69.6	12	X	75	78.2	12	X	75	79.1
13	X	70	74.6	13	X	65	70.2	13	X	65	70.1
14	X	68	71.7	14	X	70	74.8	14	X	70	74.0
15	X	67	71.1	15	X	65	69.6	15	X	65	69.9
16	X	76	78.9	16	off		83.2	16	X	70	74.3
17				17				17			
18	X	65	70.1	18	X	65	69.9	18	X	67	70.1
19	X	65	72.6	19	X	65	70.1	19	X	65	69.6
20	X	65	70.6	20	X	65	70.1	20	X	65	70.2
21	X	65	68.7	21	X	65	71.1	21	X	70	73.1
22	X	65	69.1	22	X	65	69.6	22	X	65	68.9
23	X	65	68.1	23	X	65	69.9	23	X	65	70.1
24	X	65	69.9	24	X	65	71.1	24	X	65	70.4
25	X	65	70.1	25	X	65	69.9	25	X	65	69.8
26	X	65	70.4	26	X	65	70.3	26	X	65	70.8

— Rm Not in Use

AC temp check list Date: 9-7-23 Temp outside: 100.3				AC temp check list Date: 9-11-23 temp outside: 81.6				AC temp check list Date: 9-14-23 temp outside: 80.4			
Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp	Room #	AC on (X)	AC temp	Room Temp
Bungo A	X	66	68.9	Bungo A	X	65	68.3	Bungo A		68	70.5
Bungo B				Bungo B				Bungo B			
1	X	6.5	69.2	1	X	6.5	67.2	1	off		77.5
2	X	7.0	74.2	2	X	7.0	73	2	off	68.4	72.9
3				3				3			
4	X	6.5	69.2	4	X	6.5	69.1	4	off		77.3
5	X	6.5	69.7	5	X	6.5	69.2	5	X	6.5	69.7
6	X	6.5	70.1	6	X	6.5	68.9	6	X	6.5	72.9
7	X	6.5	69.9	7	X	6.5	68.8	7	X	6.4	73.4
8	X	6.5	70.1	8	X	6.5	69.3	8	X	7.1	71.1
9	X	6.5	70.2	9	X	6.5	70.1	9	X	6.5	73.2
10	X	6.5	69.8	10	X	6.5	68.9	10	X	6.6	74.1
11	X	6.7	72	11	X	6.9	73	11	off		75.9
12	X	7.0	74.6	12	X	7.0	74.4	12	X	6.3	70.1
13	X	6.5	69.6	13	X	6.5	68.9	13	X	6.8	71.1
14	X	7.0	73.4	14	X	6.9	73.1	14	X	7.4	75.9
15	X	6.5	70.3	15	X	6.5	69.6	15	X	6.1	74.1
16	X	7.0	74.6	16	X	7.0	73.8	16	X	7.1	74.7
17				17				17			
18	X	7.6	74.3	18	X	7.0	73.9	18	off		74.5
19	X	6.5	70.4	19	X	6.5	69.6	19	X	7.3	72.9
20	X	6.5	70.2	20	X	6.5	69.4	20	X	7.0	73.6
21	X	7.0	73.9	21	X	7.6	72.8	21	Heaton	8.2	74.3
22	X	6.5	69.6	22	X	6.5	69.6	22	X	6.0	70.1
23	X	6.5	70.1	23	X	6.5	69.9	23	X	6.9	71.7
24	X	6.5	71.1	24	X	6.5	69.7	24	X	6.1	67
25	X	6.5	72	25	X	6.5	70.1	25	off		70.7
26	X	6.5	71.9	26	X	6.5	71.6	26	off		74.3

closed
good

TEST OF EMERGENCY PLANS

Power Failure

Emergency Plan

Facility Tested: Crossroads Group

Date Tested: 8/21/23

Number of Consumers Involved: 45

Number of Staff Involved: 8

Description of Test: Clients were instructed to remain calm and let staff know
about power outage. Clients were also informed that staff have flashlights in
their rooms and to remain in group rooms until power was restored.

Emergency Evacuation Conducted: Y X N If yes, complete the following:

Date: 8/21/23 How long did it take to evacuate? _____

Were evacuation procedures followed? Y N

Was key staff checking to make sure that everyone evacuated? Y N

Evaluation of Test Results: The drill was conducted in good manner and
all clients and staff were accounted for.

Staff Gathered residents to lighted areas
until power came back on.

Margaret Pally
Signature of Organizational Health and Safety Officer

8-21-23
Date

TEST OF EMERGENCY PLANS

Fire

Emergency Plan

Facility Tested: Crossroads RFC Date Tested: 8/21/23

Number of Consumers Involved: 45

Number of Staff Involved: 8

Description of Test: Sirens set off and clients were instructed to remain calm
and to walk to fence line across from building. Staff joined clients after clearing
building, conducting a count to ensure everyone was there.

Emergency Evacuation Conducted: X Y N If yes, complete the following:

Date: 8/21/23 How long did it take to evacuate? 4 mins.

Were evacuation procedures followed? X Y N

Was key staff checking to make sure that everyone evacuated? X Y N

Evaluation of Test Results: Clients remained calm and did as instructed.

Staff cleared building and joined clients. A count was conducted and all

clients were accounted for. All buildings and rooms were
checked by staff. everyone was accounted
for

Margaret Duff
Signature of Organizational Health and Safety Officer

8-21-23
Date

TEST OF EMERGENCY PLANS

Medical Emergency

Emergency Plan

Facility Tested: Crossroads RCF Date Tested: 8/21/23

Number of Consumers Involved: 45

Number of Staff Involved: 8

Description of Test: Clients were instructed of what to do in case of an
emergency. Clients participated in first aid drills and were instructed of who
to go report a medical emergency to.

Emergency Evacuation Conducted: Y X N If yes, complete the following:

Date: 8/21/23 How long did it take to evacuate? 1

Were evacuation procedures followed? Y N

Was key staff checking to make sure that everyone evacuated? Y N

Evaluation of Test Results: Clients participated in drills to ensure they know

what to do in case of medical emergency. Provided care to

resident. Called EMS they arrived 15-20 min.

after being called. Took 2 mins to removed other

residents. So that EMS could get to resident in need.

Margaret Patti
Signature of Organizational Health and Safety Officer

8-21-23
Date

TEST OF EMERGENCY PLANS

Violent Intruder

Emergency Plan

Facility Tested: Crossroads RCF Date Tested: 8/21/23

Number of Consumers Involved: 45

Number of Staff Involved: 8

Description of Test: Staff were instructed that if a violent intruder entered the building to use code "Is Dr. Richards here?" and to remain calm and call 911. Staff is to try and get intruder to remain calm while waiting on police and to get clients to safety.

Emergency Evacuation Conducted: X Y N If yes, complete the following:

Date: 8/21/23 How long did it take to evacuate?

Were evacuation procedures followed? Y N

Was key staff checking to make sure that everyone evacuated? Y N

Evaluation of Test Results: Staff acted out procedure and were able to remain calm and get clients to remain calm and get to safety by getting out exit doors on side of building. Took 4mins to get everyone to safety and locked doors. Also calmed down intruder.

Margaret Palt
Signature of Organizational Health and Safety Officer

8-21-23
Date

TEST OF EMERGENCY PLANS

Severe Weather/Tornado

Emergency Plan

Facility Tested: Crossroads RCF Date Tested: 8/21/23

Number of Consumers Involved: 45

Number of Staff Involved: 8

Description of Test: Sirens went off, clients were all instructed to quickly walk
to the hallway, sit on the floor and cover their heads. Staff cleared all rooms,
removed all paintings, and picture frames from the wall and followed the
clients into the hallway.

Emergency Evacuation Conducted: Y N If yes, complete the following:

Date: 8/21/23 How long did it take to evacuate? _____

Were evacuation procedures followed? Y N

Was key staff checking to make sure that everyone evacuated? Y N

Evaluation of Test Results: Clients remained calm and went into hallway and

sat on floor and covered their heads. Took 2mins 20sec

to get everyone in ^{the} hall + heads covered.

Margaret Pull
Signature of Organizational Health and Safety Officer

8-21-23
Date

TEST OF EMERGENCY PLANS

Bomb Threat

(In building)

Emergency Plan

Facility Tested: Cross roads RLF Date Tested: 8-21-23

Number of Consumers Involved: 45

Number of Staff Involved: 8

Description of Test: The siren went off and clients were informed of a bomb threat and asked to quickly but calmly leave building, going to the fence line across from building. Staff stayed behind to clear building, joining clients afterwards and did roll call.

Emergency Evacuation Conducted: X Y N If yes, complete the following:

Date: 8/21/23 How long did it take to evacuate? 4 minutes

Were evacuation procedures followed? X Y N

Was key staff checking to make sure that everyone evacuated? X Y N

Evaluation of Test Results: Clients cleared the building calmly and quickly.

Staff made sure all clients got out and were accounted for.

Margaret Pott
Signature of Organizational Health and Safety Officer

8-21-23
Date

TEST OF EMERGENCY PLANS

Earthquake

Emergency Plan

Facility Tested: Crossroads RCF

Date Tested: 8/21/23

Number of Consumers Involved: 45

Number of Staff Involved: 8

Description of Test: Clients and staff were informed of drill in case of earthquake,
to drop, take cover under desk, table, etc. and to hold on firmly.

Emergency Evacuation Conducted: Y X N If yes, complete the following:

Date: 8/21/23 How long did it take to evacuate? _____

Were evacuation procedures followed? Y N

Was key staff checking to make sure that everyone evacuated? Y N

Evaluation of Test Results: Clients remained calm and followed procedure.

Residents in buildings were instructed to go to
hallway and cover heads. Residents outside were
moved to their rooms and staff made sure they
were in their closets and covered their heads.
5 mins to get everyone where they needed to be.

Margaret A. [Signature]
Signature of Organizational Health and Safety Officer

8-21-23
Date



Delivery via email to: northfork@treatmentservices.org

November 2, 2023

License Number: RC4601
Survey Event ID: S9JC12

Ms. Margaret Patty, Administrator
Crossroads Residential Care
Route 2, Box 1542
Checotah, OK 74426

Dear Ms. Patty:

On **October 11, 2023**, 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 **July 18, 2023**, have now been corrected and your facility is in compliance with licensure standards effective **October 11, 2023**.

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

Respectfully,

Lisa Calvin, Enforcement Analyst
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: RC4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/11/2023
NAME OF PROVIDER OR SUPPLIER CROSSROADS RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 10/11/23. All deficiencies from 07/18/23 were corrected.	{R 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE