Oklahoma State Department of Health
Creating a State of Health

USPS Tracking# 9114 9011 5981 8322 2427 83

February 24, 2020

License Number: RC5403
Survey Event ID: 2SDR11

Ms. Addie Miller, Administrator
V-J's Residential Care Home
P.O. Box 57
Paden, OK 74860

Dear Ms. Miller:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey at your facility on February 11, 2020.

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,

Katie Stagner

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

SD/kgs
Enclosure

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FROM:

Oklahoma State Dept. of Heal
Protective Health Services - L
1000 NE 10th St
Oklahoma City OK 73117-129

TO:

Ms. Addie Miller, Administrat
V-j's Residential Care Home
PO Box 57
Paden, OK 74860-0057

This envelope is made from post-consumer waste. Please recycle - again.

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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
	RC5403	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
V-J'S RESIDENTIAL CARE HOME, LLC	224 NORTH CEDAR PADEN, OK 74860

(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 On 02/10/2020 through 02/11/2020 a re-licensure survey was conducted. Census was 18. The following deficient practice was cited.	R 000		
R 351 SS=E	310:680-7-3 INSECT AND RODENT CONTROL Methods shall be employed to prevent the entrance and harborage of insects, spiders, and rodents. Homes shall be kept free of insects, and rodents. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to have an effective pest control to keep the home free of pests and prevent harborage of bed bugs for 2 (#9 and #10) of 5 sampled residents who resided in building one. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: On 02/10/2020 the residents made no complaints of bed bugs. On 02/11/2020 at 10:35 a.m., a dead bed bug was observed in resident #9's bed. Her bed was partially covered with a plastic covering. Next to resident 10's bed was a live bed bug crawling on the floor. Medication administration technician (MAT) #4 smashed it with her shoe and blood was visible on the floor. At 11:20 a.m., the administrator was asked if she knew the home had bed bugs. She stated, "We have been spraying for bed bugs."	R 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC5403	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
V-J'S RESIDENTIAL CARE HOME, LLC	224 NORTH CEDAR PADEN, OK 74860

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R 351	Continued From page 1 At 12:09 p.m., the administrator was asked about the home's policy to reduce or rid the home from bed bugs. She stated the home was sprayed monthly. She was asked if she had identified any residents with bed bug bites. She stated no and she had not received complaints about bed bugs. All of the residents attended a day treatment program during the day.	R 351		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC5403	V-J'S RESIDENTIAL CARE HOME, LLC

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. 30875	02/10/2020	02/11/2020	1.00	0.00	7.00	0.00	8.00	2.00
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**

FEB 25 2020

Oklahoma State Department of Health
Creating a State of Health

March 10, 2020

License Number: RC5403
Survey Event ID: 2SDR11

Ms. Addie Miller, Administrator
V-J's Residential Care Home
P.O. Box 57
Paden, OK 74860

Dear Ms. Miller:

On February 11, 2020, 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 **April 4, 2020**.

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,

Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/cn

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
	RC5403	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
V-J'S RESIDENTIAL CARE HOME, LLC	224 NORTH CEDAR PADEN, OK 74860

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RECEIVED
MAR 0 5 2020
LONG TERM CARE

RECEIVED
MAR 0 6 2020
LONG TERM CARE

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eddie Mills — TITLE: Administrator — (X6) DATE: 3-9-2020

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
	RC5403	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
V-J'S RESIDENTIAL CARE HOME, LLC	224 NORTH CEDAR PADEN, OK 74860

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OKLAHOMA
State Department
of Health

Delivery via email to: von@cotc.net

November 18, 2020

License Number: RC5403
Survey Event ID: 2SDR12

Ms. Addie Miller, Administrator
V-J's Residential Care Home, Llc
224 North Cedar
Paden, OK 74860

Dear Ms. Miller:

On **November 6, 2020**, an desk audit/paper 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 **February 11, 2020,** have now been corrected and your facility is in compliance with licensure standards effective **April 4, 2020**.

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

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2020.11.18 09:00:06 -06'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

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
	RC5403	A. BUILDING: _____ B. WING _____	R 11/06/2020

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V-J'S RESIDENTIAL CARE HOME, LLC	224 NORTH CEDAR PADEN, OK 74860

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{R 000}	INITIAL COMMENTS A desk audit was conducted on 11/06/20. All deficiencies from the 02/11/20 survey have been corrected.	{R 000}		

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