OKLAHOMA
State Department
of Health

Delivery via email to: northfork@treatmentservices.org

December 30, 2022

License Number: RC4601
Survey Event ID: GD1Z11

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

Dear Ms. Phillips:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey with complaint investigation at your facility on **December 2, 2022**.

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.

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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

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

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INVESTIGATIVE REPORT

Facility: **Crossroads Residential Care**
Address: **Route 2, Box 1542**
City, State, Zip: **Checotah, OK 74426**
Provider #: **RC4601**
Complaint #: **OK00059769**
Investigation Date(s): **11/29/22 through 12/02/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to ensure residents were not involuntarily discharged.	**US**
2. The home failed to ensure medications were administered and monitored according to physician orders.	**S**
3. The home failed to have an adequate system for acquiring necessary resident medications in a timely manner.	**S**

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 11/29/2022 at 4:00 p.m.

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

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

The sampled resident's records documented the residents left the facility at their own will and transported to a safe place. Residents and staff members voiced no concerns related to involuntary discharges for the residents.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R601 for details.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R601 for details.

Determination Summary and Follow-Up Action:

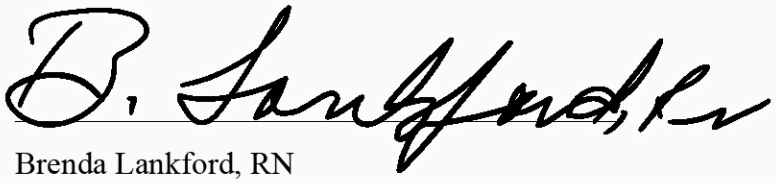
Deficient practice was substantiated for allegations #2 and #3. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation #1. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Brenda Lankford, RN

Date report completed: 12/03/2022

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 12/02/2022

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 relicensure survey was conducted from 11/29/22 through 12/02/22. A complaint investigation (#OK00059769) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. COPD - chronic obstructive pulmonary disease CT - computed tomography DM - diabetes mellitus Dr. - doctor ER - emergency room FSBS - finger stick blood sugar HTN - hypertension MAR - medication administration record MAT - medication administration technician mcg - micrograms mg - milligrams mg/dl - milligrams per deciliter Res - resident U - units UTI - urinary tract infection tabs - tablets	R 000		
R 152 SS=D	63 O.S. 1-1918.B.5. RIGHTS - Appropriate medical care Section 1-840. Other provisions applicable to residential care homes Residential care homes subject to the provisions of the Residential Care Act shall comply with the provisions of Sections 1-1909, 1-1910, 1-1914.1, 1-1914.2, 1-1915, 1-1917, 1-1918, 1-1919, 1-1920, 1-1921, 1-1922, 1-1924, 1-1926, 1-1927, 1-1930, 1-1939, 1-1940 and 1-1941 of this title.	R 152		

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R 152	Continued From page 1 63 O.S. 1-1918(B)5. Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident unless adjudged to be mentally incapacitated shall be fully informed by his attending physician of his medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. This Rule is not met as evidenced by: Based on record review and interview, the home failed to ensure a resident was sent to the ER as referred by a physician for one (#2) of eight residents sampled for appropriate medical care. The administrator identified 50 residents who resided in the facility. Findings: Res #2 had diagnoses which included DM, depression, bipolar II disorder, and HTN. A "Reason for Doctor Visit" form, dated 03/29/22, read in parts "...Reason for Doctor Visit: shaking, low energy, drooling, having trouble sleeping, she feels not like herself, no energy, weak, having trouble walking this morning...Doctor Comments on the Visit: CT head and STAT labs ER..." An urgent care transcription for Res #2's visit on	R 152		

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R 152	Continued From page 2 03/29/22 documented diagnoses of tremors and muscle weakness. The transcription documented the plan was referred resident to the emergency department at [name deleted hospital] for a CT of head and stat labs. A progress note, dated 04/03/22, documented "[Res #2 name deleted] went to the hospital via ambulance for tremors. Was returned back to the facility later that night for allergic reaction to meds." Hospital records, dated 04/03/22, documented a diagnosis of occasional tremors. The records documented labs were obtained and for the resident to follow up with her physician in two days. A physician evaluation and medication review, dated 04/06/22, documented to discontinue Haldol and Aristada (antipsychotic medications) and start Caplyta (an antipsychotic medication), Ingrezza (a medication for tardive dyskinesia), and benztropine (an anti-tremor medication). On 12/01/22 at 5:08 p.m., the administrator stated staff should have taken her straight to the ER after leaving the urgent care. She stated she was not aware the resident was referred to the ER at the urgent care visit. The administrator stated the staff who took the resident to urgent care should have notified her of the physician's referral.	R 152		
R 601 SS=E	310:680-13-1 MEDICATIONS Correct medication and pharmacy techniques and principles shall be used when medications are administered or monitored. The home shall	R 601		

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R 601	Continued From page 3 comply with the following: (1) Storage and Maintenance. This Rule is not met as evidenced by: Based on record review, observation, and interview, the home failed to ensure correct medication and pharmacy principles were used for four (#2, 3, 5, and #6) of eight residents whose medications were reviewed. The home failed to: a. ensure medications were administered as ordered and obtained from the pharmacy in a timely manner so that residents did not miss doses for Res #2, #3, #5, and #6. b. ensure insulin was administered according to physician orders, physician was notified of high readings of FSBS, and documentation was made of refused injections for Res #2, #5, and #6. The administrator identified 50 residents who resided in the facility. Findings:	R 601		

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R 601	Continued From page 4 1. Res #3 had diagnoses which included schizophrenia. A physician order, dated 11/02/22, documented haloperidol 10mg three times daily. The November 2022 MAR documented haloperidol was not administered for the following doses: ~two doses on the 18th and no reason documented, ~one dose on the 19th, 21st and 22nd and no reason documented, ~three doses on the 25th and the documented reason was the medication was out of stock, ~three doses on the 28th and 29th and no reason documented, and ~one dose on the 30th and no reason documented. On 12/01/22 at 10:26 a.m., the administrator was asked about the haloperidol not being administered. She checked the med cart and stated the medication was not in stock at that time. She stated medications should be re-ordered when there were five days of medication left. She stated the staff should document the reason a medication was not given. 2. Res #5 had diagnoses which included DM, schizophrenia, and schizoaffective disorder. The November 2022 FSBS and Novolog record documented the resident had received FSBS testing every morning until 11/10/22. The record documented, during that time, the resident's readings ranged from 311 to 387 mg/dl. The record documented Novolog sliding scale insulin	R 601		

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had been administered for those readings. There were no current physician orders to conduct the FSBS readings or for the Novolog sliding scale insulin.

A physician order, dated 11/02/22, documented Levemir Flextouch 50 U twice a day, scheduled for 8:00 a.m. and 8:00 p.m.

A physician order, dated 11/02/22, documented risperidone 2mg twice a day.

The November 2022 MAR documented risperidone was not administered for the following doses:

~one dose on the 19th,
~two doses on the 20th,
~one dose on the 21st, 22nd, and 28th, and
~two doses on the 29th and the 30th.

On 12/01/22 at 4:18 p.m., Res #5 stated she had two different glucometers and she was out of the blood glucose strips for both of the machines. Res #5 stated she had been out of strips for three weeks. The resident stated she was supposed to check her sugar once a day every morning. The resident stated she did not know she was out of risperidone.

On 12/01/22 at 4:30 p.m., the administrator checked and could not find an order for the Novolog insulin. She stated the blood glucose strips have been ordered. She stated the physician had a standing sliding scale protocol they used if a resident came in without one. The scale was asked for, but not provided. She stated the staff should have documented the reason a medication was not given. She stated the risperidone had been out of stock but had

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R 601	Continued From page 6 came in today. 3. Res #6 was admitted on 11/23/22 and had no documented diagnoses, just the instructions on the labels of the medications which the resident had brought to the home. The November 2022 MAR documented trazodone 150mg at bedtime. The MAR documented the medication was not administered the 26th through the 30th. The med cart contained two pens of Tonjeo (long acting insulin). There were no name or label with instructions on the box and it was not listed on the MAR as administered. The med cart contained four pens of Novolog Flexpen insulin. The labeled instructions documented to administer before meals and at bedtime per sliding scale. It documented the maximum daily dose was 36 U. The sliding scale the staff were using, per the administrator, was from the resident's previous stay MAR for December 2021, documented the following: 60-150 = 0 U 151-200 = 4 U 201-250 = 8 U 251-300 = 12 U 301-350 = 16 U 351-400 = 20 U over 401 = 24 U and call Dr. The November 2022 FSBS and Novolog record documented the resident had received FSBS testing 15 out of 29 opportunities. The record documented five of the 15 opportunities, the	R 601		

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resident received the incorrect amount of Novolog insulin as follows:

~25th at 6:23 p.m., FSBS 376 - 12 U
~26th at 4:00 p.m., FSBS 231 - 6 U
~27th at 6:00 a.m., FSBS 156 - 0 U
~29th at 6:00 a.m., FSBS 464 - 20 U and no documentation the physician was notified.
~30th at 6:00 a.m., FSBS 416 - 12 U and no documentation the physician was notified.

The December 2022 FSBS and Novolog record documented on the 1st at 5:00 a.m., the FSBS was 328 and no insulin was administered. There were no other entries for the remainder of the day or for the morning of the 2nd.

On 12/02/22 at 11:30 a.m., the administrator stated the staff should have called the physician when the resident's FSBS was over 401 and should have received sliding scale insulin this morning. She stated the night shift provided the finger sticks and insulin along with the residents' morning meds. She stated she checked and the resident's trazodone was not in stock and should have already been ordered. She stated the resident did not have orders when she came and the home was supposed to go by the instructions on the labels of the medications the resident had brought in. The administrator stated she called the physician today to get an order for the resident's long acting insulin.

4. Res #2 was admitted to the home on 11/16/22 and had diagnoses which included DM, depression, bipolar II disorder, and HTN.

The "Medication Release Form" (a list of medications the home had documented the resident came in with,) dated 11/16/22,

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documented the following medications and quantities which were included on the list:

metformin 100mg - 14 tablets
fluoxetine (Prozac) 40mg (an antidepressant) - 14 capsules
lamotrigine (Lamictal) 25mg - (used to treat seizures and bilpolar disorder) - 26 tablets
rosuvastatin 20mg (for high cholesterol) - 15 tablets
calcium 250mg - 29 tablets
vitamin D 25mcg - 37 tablets

The November 2022 MAR documented the resident took her last dose of metformin and rosuvastatin on the 30th. On 12/02/22, the medications were not in house.

The November 2022 MAR documented the resident received doses of Prozac on the 16th and 17th. Initials were then circled for the rest of the month indicating the medication was not administered.

The November MAR did not include the Lamictal medication or the calcium and vitamin D supplements.

A progress note, dated 11/19/22, documented the resident went to the hospital for blood sugar being 503.

A progress note, dated 11/20/22, documented the resident returned from the hospital. The note documented the resident was diagnosed with a UTI and hyperglycemia and was sent home with two antibiotics.

A "Reason for Doctor Visit" form, dated 11/29/22, documented the resident went to see the urgent

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care physician for a problem with her big toe, a spider bite on her leg, and a sinus infection. The form documented an order for cephalexin (an antibiotic), mupirocin ointment (topical antibiotic), and albuterol inhaler two puffs 3-4 times daily as needed for wheezing. A progress note, dated 11/29/22, documented the same information.

The November 2022 MAR included the oral and topical antibiotic but did not include the albuterol inhaler.

The resident's Lantus (long acting insulin) label documented to administer 45 U every morning and 35 U every night. The medication cart was observed to contain two full vials and one partial vial.

The November 2022 MAR documented Lantus insulin inject 35 U subcutaneously every night. The MAR did not contain the instructions to administer 45 U every morning as documented on the label. The MAR documented the Lantus was administrated on the 16th, 17th, and 18th at 8:00 p.m. The MAR documented the Lantus was not administered for the rest of the month.

The sliding scale the staff were using, per the administrator, was from the resident's previous stay MAR for February 2022, documented the following:

60-150 = 0 U
151-200 = 4 U
201-250 = 8 U
251-300 = 12 U
301-350 = 16 U
351-400 = 20 U
over 401 = 24 U and call Dr.

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R 601	Continued From page 10 The November 2022 FSBS and Novolog record documented the resident had received FSBS testing 34 times. According to the documentation on the record, 22 of the 34 opportunities, the resident received the incorrect amount of Novolog insulin as follows: ~17th at 9:00 a.m., FSBS 316 - 0 U ~17th at 4:20 p.m., FSBS 343 - 10 U ~18th at 6:00 a.m., FSBS 261 - 0 U This record documented 45 U of Lantus was administered. ~19th at 12:00 p.m., FSBS 367 - 12 U ~20th at 4:00 p.m., FSBS 303 - 12 U ~21st at 6:00 a.m., FSBS 241 - 0 U ~21st at 11:05 a.m., FSBS 416 - 24 U was correct but no documentation the physician was not notified. ~22nd at 6:00 a.m., FSBS 273 - 0 U ~22nd at 12:00 p.m., FSBS 189 - 2 U ~23rd at 11:05 a.m., FSBS 165 - 5 U ~24th at 6:00 a.m., FSBS 167 - 0 U ~24th at 12:00 p.m., FSBS 284 - 6 U ~24th at 3:30 p.m., FSBS 323 - 8 U ~24th at (time absent) FSBS 404 - 0 U This record documented 35 U of Lantus insulin was administered. The physician was not notified. ~25th at 6:00 a.m., FSBS 168 - 0 U ~25th at 12:00 p.m., FSBS 282 - 8 U ~26th at 6:00 a.m., FSBS 168 - 0 U ~28th at 6:00 a.m., FSBS 217 - 0 U ~28th at 12:00 p.m., FSBS 207 - 4 U ~28th at 3:46 p.m., FSBS 232 - 6 U ~29th at 12 p.m., FSBS 218 - 4 U ~30th at 6:00 a.m., FSBS 223 - 0 U ~30th at 12:00 p.m., FSBS 294 - 6 U The December 2022 FSBS and Novolog record documented the following incorrect amounts of Novolog insulin as follows:	R 601		

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 12/02/2022

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R 601	Continued From page 11 1st at 6:00 a.m., FSBS 349 - 10 U 1st at 4:00 p.m., FSBS 221 - 0 U 1st at 8:00 p.m., FSBS 445 - 0 U This record documented 35 U of Lantus insulin was administered. On 11/30/22 at 2:04 a.m., Res #2 stated she went to urgent care yesterday for a toe injury, spider bite, and was having pain when inhaling and exhaling. She stated she has COPD and asthma. She stated the home got the antibiotics she needed but did not get the inhaler the doctor prescribed. The resident stated she went to the hospital this month on the 19th and came back on the 20th. She said her sugar was high, 504. She stated she got an antibiotic for a UTI. She was asked if she received her insulin like she was supposed to. She stated she got long acting and sliding scale and did not have any problems with her insulin. On 12/02/22 at 11:58 a.m., MAT #1 was asked about the insulin not administered correctly. She stated the night shift did the insulin and medications for the diabetics in the mornings before they left. On 12/02/22 at 12:00 p.m., the administrator was shown the "Medication Release Form" (a list of medications the home had documented the resident came in with.) She was informed the Prozac medication was documented as not administered. She stated she did not know why the Prozac medication was not given. At that time she went to look for the medication and it was not found. She also looked for the Lamictal medication and found it but did not know why it was not written on the MAR. The administrator stated the staff should have called the physician when the resident's FSBS was over 401 and was	R 601		

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R 601	Continued From page 12 not aware the resident was not receiving the correct amount of insulin. She stated if the resident was refusing the Novolog, the staff should have documented the reason on the record. The administrator stated she would call the pharmacy to make sure the medication had been ordered. She said the physician would be at the home on 12/07/22 and would go over the resident's medications. On 12/14/22 at 12:14 p.m., Res #2 stated she had been receiving her Lantus insulin in the morning and evening. She stated she did not always take her sliding scale in the morning and the evenings because she got the Lantus injections at that time. She said she would take the noon dose if needed. She stated she would sometimes not follow the sliding scale and want a lower dose of Novolog. She stated she was out of some of her medications. She stated she was concerned that she did not get her inhaler. She said she felt she was not breathing well.	R 601		

OKLAHOMA
State Department
of Health

Delivery via email to: northfork@treatmentservices.org

January 17, 2023

License Number: RC4601
Survey Event ID: GD1Z11

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

Dear Ms. Phillips:

On **December 2, 2022**, a Relicensure survey and a complaint investigation 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 will be corrected and you will be in substantial compliance by **January 30, 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

Digitally signed by Tempal Killman
Date: 2023.01.17 13:16:07 -06'00'

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

enc

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R 000	INITIAL COMMENTS A relicensure survey was conducted from 11/29/22 through 12/02/22. A complaint investigation (#OK00059769) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. COPD - chronic obstructive pulmonary disease CT - computed tomography DM - diabetes mellitus Dr. - doctor ER - emergency room FSBS - finger stick blood sugar HTN - hypertension MAR - medication administration record MAT - medication administration technician mcg - micrograms mg - milligrams mg/dl - milligrams per deciliter Res - resident U - units UTI - urinary tract infection tabs - tablets	R 000		
R 152 SS=D	63 O.S. 1-1918.B.5. RIGHTS - Appropriate medical care Section 1-840. Other provisions applicable to residential care homes Residential care homes subject to the provisions of the Residential Care Act shall comply with the provisions of Sections 1-1909, 1-1910, 1-1914.1, 1-1914.2, 1-1915, 1-1917, 1-1918, 1-1919, 1-1920, 1-1921, 1-1922, 1-1924, 1-1926, 1-1927, 1-1930, 1-1939, 1-1940 and 1-1941 of this title.	R 152	BH 1-30-23 Staff will make sure all medical care is given, treatment appropriate and Timely Manner Administrator will follow up	

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R 152	Continued From page 1 63 O.S. 1-1918(B)5. Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident unless adjudged to be mentally incapacitated shall be fully informed by his attending physician of his medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. This Rule is not met as evidenced by: Based on record review and interview, the home failed to ensure a resident was sent to the ER as referred by a physician for one (#2) of eight residents sampled for appropriate medical care. The administrator identified 50 residents who resided in the facility. Findings: Res #2 had diagnoses which included DM, depression, bipolar II disorder, and HTN. A "Reason for Doctor Visit" form, dated 03/29/22, read in parts "...Reason for Doctor Visit: shaking, low energy, drooling, having trouble sleeping, she feels not like herself, no energy, weak, having trouble walking this morning...Doctor Comments on the Visit: CT head and STAT labs ER..." An urgent care transcription for Res #2's visit on	R 152	By 1-30-23 All resident Referred to ER will be sent ASAP Shall not return to facility until seen by ER. Administrator will follow up	

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R 152	Continued From page 2 03/29/22 documented diagnoses of tremors and muscle weakness. The transcription documented the plan was referred resident to the emergency department at [name deleted hospital] for a CT of head and stat labs. A progress note, dated 04/03/22, documented "[Res #2 name deleted] went to the hospital via ambulance for tremors. Was returned back to the facility later that night for allergic reaction to meds." Hospital records, dated 04/03/22, documented a diagnosis of occasional tremors. The records documented labs were obtained and for the resident to follow up with her physician in two days. A physician evaluation and medication review, dated 04/06/22, documented to discontinue Haldol and Aristada (antipsychotic medications) and start Caplyta (an antipsychotic medication), Ingrezza (a medication for tardive dyskinesia), and benztropine (an anti-tremor medication). On 12/01/22 at 5:08 p.m., the administrator stated staff should have taken her straight to the ER after leaving the urgent care. She stated she was not aware the resident was referred to the ER at the urgent care visit. The administrator stated the staff who took the resident to urgent care should have notified her of the physician's referral.	R 152	By 1-30-23 Residents Referred by Urgent Care ~~with~~ to ER will be sent without Returning to facility until ER cleared. Administrator Will follow up	
R 601 SS=E	310:680-13-1 MEDICATIONS Correct medication and pharmacy techniques and principles shall be used when medications are administered or monitored. The home shall	R 601		

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R 601	Continued From page 3 comply with the following: (1) Storage and Maintenance. This Rule is not met as evidenced by: Based on record review, observation, and interview, the home failed to ensure correct medication and pharmacy principles were used for four (#2, 3, 5, and #6) of eight residents whose medications were reviewed. The home failed to: a. ensure medications were administered as ordered and obtained from the pharmacy in a timely manner so that residents did not miss doses for Res #2, #3, #5, and #6. b. ensure insulin was administered according to physician orders, physician was notified of high readings of FSBS, and documentation was made of refused injections for Res #2, #5, and #6. The administrator identified 50 residents who resided in the facility. Findings:	R 601	By 1-30-23 All staff will have been trained to order meds in a timely manner Administrator will follow up By 1-30-23 Staff must write why Resident refuses insulin all Blood Sugars above 400 will be notified by Dr. Administrator will follow up	

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R 601	Continued From page 4 1. Res #3 had diagnoses which included schizophrenia. A physician order, dated 11/02/22, documented haloperidol 10mg three times daily. The November 2022 MAR documented haloperidol was not administered for the following doses: ~two doses on the 18th and no reason documented, ~one dose on the 19th, 21st and 22nd and no reason documented, ~three doses on the 25th and the documented reason was the medication was out of stock, ~three doses on the 28th and 29th and no reason documented, and ~one dose on the 30th and no reason documented. On 12/01/22 at 10:26 a.m., the administrator was asked about the haloperidol not being administered. She checked the med cart and stated the medication was not in stock at that time. She stated medications should be re-ordered when there were five days of medication left. She stated the staff should document the reason a medication was not given. 2. Res #5 had diagnoses which included DM, schizophrenia, and schizoaffective disorder. The November 2022 FSBS and Novolog record documented the resident had received FSBS testing every morning until 11/10/22. The record documented, during that time, the resident's readings ranged from 311 to 387 mg/dl. The record documented Novolog sliding scale insulin	R 601	By 1-30-23 all staff will be trained in administering medications in a timely manner will also be trained in ordering medication in a timely manner Administrator will follow up By 1-30-23 all staff to order medications ~~by~~ 10 days prior to running out. Administrator will follow up	

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R 601	Continued From page 5 had been administered for those readings. There were no current physician orders to conduct the FSBS readings or for the Novolog sliding scale insulin. A physician order, dated 11/02/22, documented Levemir Flextouch 50 U twice a day, scheduled for 8:00 a.m. and 8:00 p.m. A physician order, dated 11/02/22, documented risperidone 2mg twice a day. The November 2022 MAR documented risperidone was not administered for the following doses: ~one dose on the 19th, ~two doses on the 20th, ~one dose on the 21st, 22nd, and 28th, and ~two doses on the 29th and the 30th. On 12/01/22 at 4:18 p.m., Res #5 stated she had two different glucometers and she was out of the blood glucose strips for both of the machines. Res #5 stated she had been out of strips for three weeks. The resident stated she was supposed to check her sugar once a day every morning. The resident stated she did not know she was out of risperidone. On 12/01/22 at 4:30 p.m., the administrator checked and could not find an order for the Novolog insulin. She stated the blood glucose strips have been ordered. She stated the physician had a standing sliding scale protocol they used if a resident came in without one. The scale was asked for, but not provided. She stated the staff should have documented the reason a medication was not given. She stated the risperidone had been out of stock but had	R 601	By 1-30-23 All Staff will be trained in Reading Mars Making sure Mars match Dr. orders not to give medications not on Mar Administrator will follow up. By 1-30-23 Medications will be Ordered and in stock in a timely manner Administrator will follow up By 1-30-23 all insulin dependant Residents will have a sliding scale on Mars Administrator will follow up	

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R 601	Continued From page 6 came in today. 3. Res #6 was admitted on 11/23/22 and had no documented diagnoses, just the instructions on the labels of the medications which the resident had brought to the home. The November 2022 MAR documented trazodone 150mg at bedtime. The MAR documented the medication was not administered the 26th through the 30th. The med cart contained two pens of Tonjeo (long acting insulin). There were no name or label with instructions on the box and it was not listed on the MAR as administered. The med cart contained four pens of Novolog Flexpen insulin. The labeled instructions documented to administer before meals and at bedtime per sliding scale. It documented the maximum daily dose was 36 U. The sliding scale the staff were using, per the administrator, was from the resident's previous stay MAR for December 2021, documented the following: 60-150 = 0 U 151-200 = 4 U 201-250 = 8 U 251-300 = 12 U 301-350 = 16 U 351-400 = 20 U over 401 = 24 U and call Dr. The November 2022 FSBS and Novolog record documented the resident had received FSBS testing 15 out of 29 opportunities. The record documented five of the 15 opportunities, the	R 601	1-30-23 All new Residents or Returning Residents will have correct medication and or insulin on hand to be properly administered. Administrator will follow up By 1-30-23 All Residents will documented diagnosis in facility follow up by Administrator By 1-30-23 All staff will be trained in Reading insulin sliding Scales Administrator will follow up	

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R 601	Continued From page 7 resident received the incorrect amount of Novolog insulin as follows: ~25th at 6:23 p.m., FSBS 376 - 12 U ~26th at 4:00 p.m., FSBS 231 - 6 U ~27th at 6:00 a.m., FSBS 156 - 0 U ~29th at 6:00 a.m., FSBS 464 - 20 U and no documentation the physician was notified. ~30th at 6:00 a.m., FSBS 416 - 12 U and no documentation the physician was notified. The December 2022 FSBS and Novolog record documented on the 1st at 5:00 a.m., the FSBS was 328 and no insulin was administered. There were no other entries for the remainder of the day or for the morning of the 2nd. On 12/02/22 at 11:30 a.m., the administrator stated the staff should have called the physician when the resident's FSBS was over 401 and should have received sliding scale insulin this morning. She stated the night shift provided the finger sticks and insulin along with the residents' morning meds. She stated she checked and the resident's trazodone was not in stock and should have already been ordered. She stated the resident did not have orders when she came and the home was supposed to go by the instructions on the labels of the medications the resident had brought in. The administrator stated she called the physician today to get an order for the resident's long acting insulin. 4. Res #2 was admitted to the home on 11/16/22 and had diagnoses which included DM, depression, bipolar II disorder, and HTN. The "Medication Release Form" (a list of medications the home had documented the resident came in with,) dated 11/16/22,	R 601	By 1-30-23 Staff will call Dr. OA any BS over 400 or Dr orders for recommendation Administrator will follow up By 1-30-23 Staff will follow all guidlines for insulin making sure insulin is given also in house. Following making sure medication are in stock and given Administrator will follow up	

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R 601	Continued From page 8 documented the following medications and quantities which were included on the list: metformin 100mg - 14 tablets fluoxetine (Prozac) 40mg (an antidepressant) - 14 capsules lamotrigine (Lamictal) 25mg - (used to treat seizures and bilpolar disorder) - 26 tablets rosuvastatin 20mg (for high cholesterol) - 15 tablets calcium 250mg - 29 tablets vitamin D 25mcg - 37 tablets The November 2022 MAR documented the resident took her last dose of metformin and rosuvastatin on the 30th. On 12/02/22, the medications were not in house. The November 2022 MAR documented the resident received doses of Prozac on the 16th and 17th. Initials were then circled for the rest of the month indicating the medication was not administered. The November MAR did not include the Lamictal medication or the calcium and vitamin D supplements. A progress note, dated 11/19/22, documented the resident went to the hospital for blood sugar being 503. A progress note, dated 11/20/22, documented the resident returned from the hospital. The note documented the resident was diagnosed with a UTI and hyperglycemia and was sent home with two antibiotics. A "Reason for Doctor Visit" form, dated 11/29/22, documented the resident went to see the urgent	R 601	By 1-30-23 Staff will be trained to follow mars, making sure to have a supply of medications on stock. Administrator will follow up By 1-30-23 Staff to follow all orders on Mars. Not to overlook Meds will follow up By Administrator	

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R 601	Continued From page 9 care physician for a problem with her big toe, a spider bite on her leg, and a sinus infection. The form documented an order for cephalexin (an antibiotic), mupirocin ointment (topical antibiotic), and albuterol inhaler two puffs 3-4 times daily as needed for wheezing. A progress note, dated 11/29/22, documented the same information. The November 2022 MAR included the oral and topical antibiotic but did not include the albuterol inhaler. The resident's Lantus (long acting insulin) label documented to administer 45 U every morning and 35 U every night. The medication cart was observed to contain two full vials and one partial vial. The November 2022 MAR documented Lantus insulin inject 35 U subcutaneously every night. The MAR did not contain the instructions to administer 45 U every morning as documented on the label. The MAR documented the Lantus was administrated on the 16th, 17th, and 18th at 8:00 p.m. The MAR documented the Lantus was not administered for the rest of the month. The sliding scale the staff were using, per the administrator, was from the resident's previous stay MAR for February 2022, documented the following: 60-150 = 0 U 151-200 = 4 U 201-250 = 8 U 251-300 = 12 U 301-350 = 16 U 351-400 = 20 U over 401 = 24 U and call Dr.	R 601	By 1-30-23 Staff will follow up with all medications at Pharmacy. Finding out why medications are not in stock. Administrator will follow up By 1-30-23 Staff will follow directions on med labels Administrator will follow up.	

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 12/02/2022

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

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R 601	Continued From page 10 The November 2022 FSBS and Novolog record documented the resident had received FSBS testing 34 times. According to the documentation on the record, 22 of the 34 opportunities, the resident received the incorrect amount of Novolog insulin as follows: ~17th at 9:00 a.m., FSBS 316 - 0 U ~17th at 4:20 p.m., FSBS 343 - 10 U ~18th at 6:00 a.m., FSBS 261 - 0 U This record documented 45 U of Lantus was administered. ~19th at 12:00 p.m., FSBS 367 - 12 U ~20th at 4:00 p.m., FSBS 303 - 12 U ~21st at 6:00 a.m., FSBS 241 - 0 U ~21st at 11:05 a.m., FSBS 416 - 24 U was correct but no documentation the physician was not notified. ~22nd at 6:00 a.m., FSBS 273 - 0 U ~22nd at 12:00 p.m., FSBS 189 - 2 U ~23rd at 11:05 a.m., FSBS 165 - 5 U ~24th at 6:00 a.m., FSBS 167 - 0 U ~24th at 12:00 p.m., FSBS 284 - 6 U ~24th at 3:30 p.m., FSBS 323 - 8 U ~24th at (time absent) FSBS 404 - 0 U This record documented 35 U of Lantus insulin was administered. The physician was not notified. ~25th at 6:00 a.m., FSBS 168 - 0 U ~25th at 12:00 p.m., FSBS 282 - 8 U ~26th at 6:00 a.m., FSBS 168 - 0 U ~28th at 6:00 a.m., FSBS 217 - 0 U ~28th at 12:00 p.m., FSBS 207 - 4 U ~28th at 3:46 p.m., FSBS 232 - 6 U ~29th at 12 p.m., FSBS 218 - 4 U ~30th at 6:00 a.m., FSBS 223 - 0 U ~30th at 12:00 p.m., FSBS 294 - 6 U The December 2022 FSBS and Novolog record documented the following incorrect amounts of Novolog insulin as follows:	R 601	By 1-30-23 Staff will be trained to learn how to Read Said Sliding Scales Administrator will follow up	

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R 601	Continued From page 11 1st at 6:00 a.m., FSBS 349 - 10 U 1st at 4:00 p.m., FSBS 221 - 0 U 1st at 8:00 p.m., FSBS 445 - 0 U This record documented 35 U of Lantus insulin was administered. On 11/30/22 at 2:04 a.m., Res #2 stated she went to urgent care yesterday for a toe injury, spider bite, and was having pain when inhaling and exhaling. She stated she has COPD and asthma. She stated the home got the antibiotics she needed but did not get the inhaler the doctor prescribed. The resident stated she went to the hospital this month on the 19th and came back on the 20th. She said her sugar was high, 504. She stated she got an antibiotic for a UTI. She was asked if she received her insulin like she was supposed to. She stated she got long acting and sliding scale and did not have any problems with her insulin. On 12/02/22 at 11:58 a.m., MAT #1 was asked about the insulin not administered correctly. She stated the night shift did the insulin and medications for the diabetics in the mornings before they left. On 12/02/22 at 12:00 p.m., the administrator was shown the "Medication Release Form" (a list of medications the home had documented the resident came in with.) She was informed the Prozac medication was documented as not administered. She stated she did not know why the Prozac medication was not given. At that time she went to look for the medication and it was not found. She also looked for the Lamictal medication and found it but did not know why it was not written on the MAR. The administrator stated the staff should have called the physician when the resident's FSBS was over 401 and was	R 601	1-30-23 Staff will follow up on all medications sent from pharmacy. Administrator will follow up	

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R 601	Continued From page 12 not aware the resident was not receiving the correct amount of insulin. She stated if the resident was refusing the Novolog, the staff should have documented the reason on the record. The administrator stated she would call the pharmacy to make sure the medication had been ordered. She said the physician would be at the home on 12/07/22 and would go over the resident's medications. On 12/14/22 at 12:14 p.m., Res #2 stated she had been receiving her Lantus insulin in the morning and evening. She stated she did not always take her sliding scale in the morning and the evenings because she got the Lantus injections at that time. She said she would take the noon dose if needed. She stated she would sometimes not follow the sliding scale and want a lower dose of Novolog. She stated she was out of some of her medications. She stated she was concerned that she did not get her inhaler. She said she felt she was not breathing well.	R 601	1-30-23 Staff will Report all Refusals to Administrator asap Staff will write why medication is out, why Client Refuse so the Client can be Counsiled up this medication is important to take. Administrator Will follow up	

OKLAHOMA
State Department
of Health

Delivery via email to: northfork@treatmentservices.org

February 6, 2023

License Number: RC4601
Survey Event ID: GD1Z12

Ms. Shawna Phillips, Administrator
Crossroads Residential Care
Route 2 ,box 1542
Checotah, OK 74426

Dear Ms. Phillips:

On **February 3, 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 **December 2, 2022,** have now been corrected and your facility is in compliance with licensure standards effective **January 30, 2023**.

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

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{R 000}	INITIAL COMMENTS A revisit was conducted on 02/03/23. All deficiencies from the 12/02/22 survey were cleared.	{R 000}		

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