



Oregon

Kate Brown, Governor

Department of Human Services
Office of Licensing & Regulatory Oversight
PO Box 14530, Salem, OR 97309
3406 Cherry Ave NE, Salem, OR 97303
Phone: (503) 373-2227
Fax (503) 378-8966



July 31, 2015

Arthur Johnson, Administrator
Oregon City Residential Care
515 10th St
Oregon City, OR 97045

Re: Provider # 50M094

Dear Ms/Mr Johnson:

Enclosed is your Residential Care Facility License which expires on January 31, 2017. If you have any questions, please feel free to call me.

Sincerely,

Carolyn Ramus, Licensing Specialist
Office of Licensing and Quality of Care
503-945-5853 *373.2130*

cc: Local Unit: Milwaukie SPD
Fire Marshall
CCMU: Tualatin
Files

5. Applicant (licensee) information: Applicant is owner and operator/manager
 Applicant is not owner and operator/manager

Operator/management is: Arthur V. Johnson **Attach separate application.**

Name of legal owning entity (exactly as registered with the Oregon Secretary of State Corporation Division):

Valley View Care Center EIN or tax identification number: XXXXXXXXXX

Street address: 515 10th st

City/state/ZIP: Oregon City OR 97045 Contact name: Arthur Johnson

Phone: 503 - 880 - 1853 FAX: 503 - 657 - 4212 Email: avjohnson@me.com

Type of business: For profit corporation LLC Partnership Sole proprietorship
 LLP Tribal Not for profit corporation Government owned Other

If other, please specify: _____

Workers' compensation carrier: ~~Land+~~ Saif Corp.

Is applicant current on payment? Yes No Policy number: 989596

Part 2 - Ownership or control interests

A. List the name and address for individuals and the EINs for organizations having **direct or indirect ownership** or controlling interest in the provider entity (see instructions for definition of ownership and controlling interest). Attach additional pages as necessary to list all officers, ownership individuals and entities with five percent (5%) or more direct or indirect ownership.

Name	Title	Address	EIN	Percentage of ownership	Entity type*
Valley View Care C	DBA	515 10th st Oregon City OR 970		100	4

*Entity type: In the "entity type" field, enter one of the codes listed below for each individual listed.
 1. Sole proprietorship 2. Partnership 3. Unincorporated associations
 4. Corporation 5. Government or tribal 6. Other (specify):

B. List the name, address and employer identification number of each person or entity with an ownership or controlling interest **in any subcontractor** in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.

Name	Title	Address	TIN	Percentage

- C. List those persons named in A or B that are related to each other (spouse, parent, child, sibling or other family members by marriage or otherwise).

Name	Relationship	Address

- D. List the name, address, EIN and DHS provider number of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or control interest of at least five percent (5%) or more. For example, are any owners of the disclosing entity also owners of Medicare or Medicaid facilities? (Example, sole proprietor, partnership or members of board of directors.)

Name	Address	EIN	DHS provider number

- E. List the name, title, and address of any individual or entity with an ownership or controlling interest in the disclosing entity that has been suspended or debarred from participation in Medicare, Medicaid or Title XX program.

Name	Title	Address

- F. List each long term care facility (include RCFs, ALFs and Nursing Facilities (NF)) in Oregon or any other state owned or managed by any person owning five percent (5%) or more of this facility.

Facility name	Address

- G. Please respond to the questions below:

Question A: Yes No

Question B: Yes No

Questions A and B: Check "Yes" or "No" for each question. For each "Yes" attach an explanation including specific circumstances (who, what, where and when) and how each was resolved.

A. Has any owning individual or owning entity currently or previously held any ownership interest in any facility (See Direction page for definition) providing services to any individuals for which license, registration or certification was either denied or involuntarily terminated, or terminated voluntarily during a state or federal termination process during the past five years?

B. Has any owning individual or owning entity currently or previously owned or operated any facility which had its license denied or revoked or received notice of the same under the laws of any state during the past five years?

Part 3 - Status changes

A. Has there been a change in ownership or control within the last year?

No Yes If yes, give date: / /

Do you anticipate any change of ownership or control within the year?

No Yes If yes, give date: / /

B. Have you filed for bankruptcy within the last two years?

No Yes If yes, when? / /

C. Do you anticipate filing for bankruptcy within a year?

No Yes If yes, when? / /

D. If this facility is operated by a management company or leased in whole or in part by another organization, has there been a change in management within the past year? No Yes.

Name of management entity if other than owner (licensee):

Give date of change in operations: / /

E. Has there been a change in administrator within the last year? (If "yes", please check box below and list date.)

Administrator Date: 8 / 7 / 2014 Name of new administrator: Arthur V. Johnson

F. Is this facility chain-affiliated? No Yes (If yes, list name, address of corporation and EIN.)

Name	Address	EIN

If the answer to F is no, was the facility ever affiliated with a chain? No Yes

If yes, list name, address of corporation and EIN.

Name	Address	EIN

Part 4 - Board of directors

If the disclosing entity is a corporation (for example, for profit, non-profit, limited liability or other corporate form) with a board of directors, list the full name with middle initial, title and address of the current directors (members).

Name	Title	Address
Arthur V. Johnson	President	505 10 th St Oregon City OR 97045

Provider signature

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of application. By signing this Disclosure Statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above and (b) the information above is true and accurate. You agree to inform the Department of Human Services (DHS) or its designee, in writing, within thirty days (30) of any changes or if additional information becomes available.

I, the undersigned, an authorized representative of the applicant (licensee) declare to the best of my knowledge this information is true, correct and complete. I give Seniors and People with Disabilities (SPD) permission to obtain payment information from the workers' compensation carrier and any entity from which the applicant leases building, property or business.

Arthur Johnson
Name of authorized representative

President
Title

Arthur Johnson
Signature

1/14/15
Date

Part 5 - Credit check authorization for licensee

Consent for business credit record check:

I, Arthur Johnson, an authorized representative for the business identified below, hereby consent to a release of credit history regarding this business to the Department of Human Services, Seniors and People with Disabilities, State of Oregon. This consent expires 24 months after the date signed.

Name of business (licensee): Valley View Care Centers Inc.

Business mailing address (include City, State and ZIP code):

515 10th St Oregon City OR 97045

Other names (DBA's) used by this business:

Oregon City Residential Care

Name of authorized representative: Arthur Johnson

Title of representative: President

Signature: Arthur Johnson Date signed: 1/14/2015

One credit check form must be completed for each business with an ownership interest of five percent (5%) or more in the applicant. OAR 411-054-0013 (2b).

Photocopy additional forms as needed. Credit records kept confidential unless disclosure is court-ordered

Part 6: Medicaid contract

- Renewal. Facility currently has a Medicaid contract. (Complete contact information section below.)
- Renewal. Facility does not have a contract.
- New facility Change of ownership

- No New owning entity chooses *not* to participate in the Medicaid program.
- Yes New owning entity hereby requests a contract for provision of residential care services to Medicaid-eligible clients of the Department of Human Services, Seniors and People with Disabilities (DHS/SPD). (Complete contact information section below.)

Please read the following information carefully.

- If the YES box has been checked, a contract for services will be mailed or faxed to you for your review and signature. The contract will not be effective until it has been signed by all parties. One of the requirements of the contract is submission of proof of three types of insurance: automobile, general liability and professional liability. DHS/SPD will sign the contract only after the contractor's insurance documentation has been received by the DHS Office of Contracts and Procurement.
- Medicaid payments will not be made to the new owner for services provided prior to the effective date of the new Medicaid contract.
- Individuals, corporations, companies and entities unable to secure any of the necessary insurances will be ineligible for the contract and will be unable to provide services to Medicaid-eligible DHS/SPD clients.
- The prior owner of the facility will not receive payment for services provided to Medicaid-eligible residents once the change of ownership has occurred.

Contact Information

In order to insure that an authorized person will receive, obtain signatures and return the contract, Please complete all the requested information below.

Contact person for the licensee/owner:

Name (print or type):	Arthur Johnson	
Title:	President	
Address:	505 10 th st	
City/state/ZIP:	Oregon City, OR, 97045	
Direct phone number:	503-880-1853	FAX: 503-657-4212
Email address:		

Attach a copy of EIN Confirmation Notice or a copy of recent letter from IRS with EIN circled. Will the facility have a contract with other state agencies? (i.e. Seniors and People with Disabilities, Developmental Disabilities, Addictions and Mental Health) No Yes

If yes please specify:

Clackamas County mental Health

- Occupancy Inspection
- New Construction
- Tenant Improvement
- Other _____

CLACKAMAS FIRE DISTRICT #1

Occ# 11282

INSPECTION NOTICE

Page 1 of 1

Business Name Deacon City Residential Care Date Nov 1 21 2015

Occupant/Owner Arthur Johnson Occupancy R-2

Address 5115 10th St O.C. Oregon 97045

The following fire safety deficiencies must be corrected in compliance with applicable state and local fire prevention laws:

1. Ensure all deficiencies from alarm and sprinkler reports John
2. Sprinkler heads in kitchen not properly installed John
3. Replace painted sprinkler heads John
4. Sprinkler system due for 5 year service John
5. F.D.C. is in need of service John
6. Provide sign for F.D.C. on wall John

If applicable, e-mail annual inspection reports to inspections@ccfd1.com

Failure to correct the above conditions by 4:30 days will make you liable to prosecution. Should fire result from such conditions, you may be liable for damages to persons or property under provisions of ORS 479.190.

Clackamas Fire District #1
 2930 S.E. Oak Grove Blvd.
 Milwaukie, OR 97267
 Bus (503) 742-2660

- 1st Notice (see back)
- 2nd Notice
- Final Notice

Fire Marshal Representative A. P. [Signature]

Presented to [Signature]

Go to www.clackamasfire.com for more information or to provide feedback.

- Occupancy Inspection
- New Construction
- Tenant Improvement
- Other _____

CLACKAMAS FIRE DISTRICT #1

Occ# 11282

INSPECTION NOTICE

Page 1 of 1

Business Name Oregon City Residential Care Date April 21 2015

Occupant/Owner Arthur Johnson Occupancy R-2

Address 515 10th St O.C. Oregon 97005

The following fire safety deficiencies must be corrected in compliance with applicable state and local fire prevention laws:

1. Ensure all deficiencies from alarm and sprinkler reports ^{are} corrected.
2. Sprinkler heads in kitchen not properly installed.
3. Replace painted sprinkler heads.
4. Sprinkler system due for 5 year service.
5. FDC is in need of service.
6. Provide sign for FDC on wall.

If applicable: e-mail annual inspection reports to inspections@ccfd1.com

Failure to correct the above conditions by 45 days will make you liable to prosecution. Should fire result from such conditions, you may be liable for damages to persons or property under provisions of ORS 479.190.

Clackamas Fire District #1
2930 S.E. Oak Grove Blvd.
Milwaukie, OR 97267
Bus (503) 742-2660

- 1st Notice (see back)
- 2nd Notice
- Final Notice

Fire Marshal Representative A.M.O.

Presented to [Signature]

Go to www.clackamasfire.com for more information or to provide feedback.

Fax Cover Sheet

Ellendale Residential Care Center

511 E. Ellendale Ave.
Dallas, Oregon, 97338
Phone: 503-623-3709
Fax: 503-623-7029

Send to: <i>Becky mason</i>	From: <i>Arthur Johnson</i>
Fax: <i>503-378-8966</i>	Date: <i>7-22-15</i>
Resident	DOB: <i>503-880-1853</i>

Urgent/
 Reply ASAP/
 Please comment/
 Please review
 For your information

TOTAL PAGES _____



Hello Becky,

Attached please find fire marshal inspection notice for Oregon city.

All items are completed -

Thank you

Arthur Johnson

LICENSE RENEWAL

EXPIRATION 1/31/2015

FACILITY NAME
ADDRESS
CITY ZIP

Oregon City Nest Care

CCMU#

50409A

Policy Analyst

Becky

Notice Sent To Facility (Via Invoice 90-Days Prior) November 1, 2014

Fee\$

AR

Paid

Date Application Received

1/20/15

em art

Date of FM Inspection

4/2/15

6/19/15

Secretary Of State (Owner, mgmt & ABN Verify)

Criminal History Ok

OIG Ok

EPLS Ok Medicaid only facilities

*Date rec'd last documents/
Complete application

7/23/15

Corrective Action Coordinator

Christina

7/23/15

Sanctions / Complaints Ok Date

7/3/15

Comments

See Attached

Last Survey

5/23/14

Revisit?

In Compliance

Decision: Comments

Deny

Hold (See E-mail)

Approval Date

7-31-15

Policy Analyst (Signature)

Rebecca Maps

Comments

Survey / License Alignment Suspended

PRORATED INVOICE SENT

\$

VERIFY PAYMENT OF PRORATED FEE

NEW RENEWAL DATE

MAILED NEW LICENSE

Freeman Lynda A

From: Higby Christina J
Sent: Friday, July 31, 2015 9:00 AM
To: Freeman Lynda A
Subject: RE: Oregon City Residential

No CA issues. ☺

Christina

Christina Higby
Corrective Action Coordinator
Office of Licensing and Regulatory Oversight
Department of Human Services
(503) 373-2072
Fax: (503) 378-8966

From: Freeman Lynda A
Sent: Thursday, July 23, 2015 3:04 PM
To: Higby Christina J
Subject: Oregon City Residential

Christina,
We have a complete application for Oregon City Residential.

Do you have any corrective action at this time preventing us from issuing a license renewal?

Thanks,
lynda