OKLAHOMA
State Department
of Health

**Delivery via email to:** Curtis@HeritageOKC.com

September 23, 2021

License Number: AL0905

Mr. Curtis Aduddell, Administrator
Heritage Assisted Living
9025 Nw Expressway
Yukon, OK 73099

**Survey Event ID: 6RKC11**

Dear Mr. Aduddell:

On **July 28, 2021**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action will be completed for each violation; and

(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. 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 the completed form for your files.

In accordance with O.S. 63-1-895, 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 833AL). 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 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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:

OKLAHOMA
State Department
of Health

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.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

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

Enclosure

Oklahoma State
Department of Health

# INVESTIGATIVE REPORT
# LICENSURE

**Facility:** **Heritage Assisted Living**
**Address:** **9025 NW Expressway**
**City, State, Zip:** **Yukon, OK 73099**
**Provider #:** **AL0905**
**Complaint #:** **OK00057424**
**Investigation Date(s):** **07/21/21 through 07/23/21 and 07/28/21**

| ALLEGATION(S) | S = SUBSTANTIATED<br>US = UNSUBSTANTIATED |
|---|---|
| 1. The center failed to ensure resident safety, provide adequate supervision to prevent elopement. | S |

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

An unannounced on-site investigation was initiated on Wednesday, July 21, 2021 at 11:00 a.m.

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

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:**

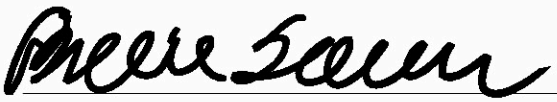
**Allegation #1**: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1512 and C1914for details.

**Determination Summary and Follow-Up Action:**

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor 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 state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.



Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 07/28/2021

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| C 000 | INITIAL COMMENTS<br><br>An abbreviated survey was conducted on 07/21/21 through 07/23/21 and 07/28/21 to investigate complaint #OK00057424.<br><br>Total residents: 68 | C 000 | | |
| C1512 SS=J | 310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect<br><br>Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B<br><br>63 O.S. 1-1918.(B)(12)<br>(12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;<br><br>Title 43A O.S. 10-103. Definitions<br>8. "Abuse" means causing or permitting:<br>a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint | C1512 | | |

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| C1512 | Continued From page 1<br>or confinement, or mental anguish, or<br>b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult;<br><br>10. "Neglect" means:<br>a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest,<br>b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or<br>c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services;<br><br>This REQUIREMENT is not met as evidenced by:<br>On 07/22/21, an Immediate Jeopardy (IJ) situation was determined to exist when the center failed to provide supervision and implement interventions to prevent elopement for resident #1 who had a known history of exit seeking.<br><br>At 4:15 p.m., the Oklahoma State Department of Health (OSDH) verified the existence of the IJ situation. The administrator and director of nursing (DON) were notified of the IJ situation related to the resident's elopement.<br><br>At 5:26 p.m., the administrator and DON submitted an acceptable plan of removal. The | C1512 | | |

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| C1512 | Continued From page 2<br>plan of removal documented the following:<br><br>Plan of Removal<br><br>1- Staff Education: To be completed 7/23/21 by 11:45 a.m., by DON and/or administrator<br>a. 1 hour safety checks to be documented hourly on paper format until IT [information technology] is able to remove the 1 hour window in the computer.<br>b. What to do when a door alarm sounds.<br>c. Missing Residents/What to do for an elopement? Including filling out, investigating and submitting State Reportable Incidents.<br><br>2- Family or Facility to provide 1:1 sitter- To be completed immediately unless door volumes can be increased so as to hear them from Nurses' Station then 1 hour safety checks including documenting visualization.<br><br>3- Investigate and report incident occurring 6/17/21- To be completed today.<br><br>4- No other Residents are at risk for elopement at this time.<br><br>On 07/23/21 at 11:35 a.m., the plan of removal (POR) had not been completed. Three staff members were contacted via text and given the in-service information but had not responded. The administrator was asked for an addendum to address the three staff members.<br><br>An amended POR was provided and documented:<br><br>Employees who are unable to be in-serviced will be in-serviced prior to returning to work. | C1512 | | |

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| C1512 | Continued From page 3<br>On 07/23/21, the in-services and one hour safety check documentation was reviewed. Staff interviews were conducted to verify the plan of removal was completed. The immediacy was removed on 07/23/21 at 11:45 a.m. The deficient practice remained at an isolated level.<br><br>Based on observation, interview and record review, it was determined the center failed to:<br><br>~ ensure the safety alarm on an exit door could be heard throughout the inside of the building;<br><br>~ provide supervision to prevent elopement for a cognitively impaired resident with exit-seeking behavior; and<br><br>~ implement interventions to prevent elopement for a resident with a history of elopement and exit seeking behavior for one (#1) of one sampled resident who was identified as an elopement risk.<br><br>The center identified one resident who was an elopement risk and six residents who were oriented to self only.<br><br>Findings:<br><br>The center's policy titled, "Probationary Residency Evaluation Period," documented, "...To allow an applicant whose eligibility is questionable to try living at the facility...Director of Nursing and/or Director of Admissions to offer residency to applicants...on probationary status for specified evaluation period by the end of this evaluation period, such residents must clearly...Be able to find the dining room and their dwelling unit without assistance. They must have minimal difficulty with time/place/person orientation. Anyone who has a tendency to wander outside or | C1512 | | |

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| C1512 | Continued From page 4 | C1512 | | |

into other residents' dwelling units is inappropriate for residency..."

The center's procedure titled, "Sign Out/Sign In," documented, "...When leaving the building all residents are asked to sign out when they leave the building and sign in when they return..."

Resident #1 was admitted to the center on 03/08/21 with diagnoses which included dementia.

An admission assessment, dated 03/08/21, documented the resident was oriented to self only, confused and had fair judgment, calm mood, and no behaviors.

A nurses' progress note, dated 03/23/21, documented, "Resident having difficult transition...confusion, exit seeking, Family here for compassionate care visit, will reach out to PCP [primary care physician] for medication consult to discuss medication for memory & anxiety. Family also in agreement to move her apartment...to help keep her more engaged in activities & increase distance to exit doors. Will monitor."

A nurse's progress note, dated 03/23/21 at 5:30 p.m., documented the resident was confused and independent with the elevator, went to the first floor with her purse around her neck and her walker seat had her personal belongings. The note documented the resident stated, "I'm going home." The note documented the resident was redirected and provided 1:1 engagement.

A nurse's progress note, dated 03/24/21 at 11:10 a.m., documented, "Resident found in great room near front exit with purse around her neck, bag of

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| C1512 | Continued From page 5 | C1512 | | |

personal belongings on walker and stating 'I'm going home' verbal redirection unsuccessful, [name-withheld staff member] assisted and was able to redirect to the dining room to have a drink, resident has been persistent in "going home", requiring 1:1 engagement, spoke with son regarding AL [assisted living] services, safety of resident and potential options."

A nurse's progress note, dated 03/25/21, documented, "Was informed today that Resident called 911 on 3/20/21 reporting she did not live here. OKCPD [Oklahoma City Police Department] came and did welfare check on 3/20/21."

An in-house incident/accident report, dated 06/17/21 at 8:00 p.m., documented, "...staff went to take trash out, came back looked-up and saw resident on easement of NW Expressway, apparently exited side emergency door..." The report documented the resident was awake, alert and oriented to self, and was put on one hour checks by the licensed practical nurse (LPN).

A nurses' progress note, dated 06/18/21, documented, "Resident persistent in exit-seeking this afternoon, has to be redirected by staff , one on one supervision. Spoke to son and discussed risk of elopement, appropriateness of care in AL setting if exit seeking continues, this nurse set up q [every] 1 [hour] checks with staff communication plan, incident report completed for 06/17/21."

An undated addendum to the care plan, documented to do hourly safety checks with staff and escort the resident to and from meals and activities for safety until family finds memory care placement.

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| C1512 | Continued From page 6<br><br>A physician incident notification, dated 06/18/21, documented, "...Resident exited facility and was found by staff standing [with] walker on shoulder of NW Expressway the evening of 06/17/21. Staff directed resident into facility. Emergency exit on west side of facility alarm was engaged indicating possible exit point. Son was called by staff & notified resident was put on increased monitoring by overnight LPN...Resident had 0 [zero] injuries. Resident AAOx1[awake, alert, and oriented to self] upon this LPN assessment on 06/18/21. Put resident on [every] 1 [hour] safety checks discussed [with] son concerns and he is looking for placement in a secure memory care unit. He is out of town currently. Staff educated and made aware of elopement risks and [every] 1 [hour] checks..."<br><br>The physician responded to the notification on 06/25/21 at 12:49 p.m. via facsimile. The physician documented in the space provided on the form for a response as follows..."Agree needs placement in secure unit with monitoring/memory care. Update me when found to send orders."<br><br>A nurse's progress note, dated 07/01/21, documented, "Resident has been exit-seeking throughout day, staff successful with redirection/diversion tactics, spoke with [name-withheld family member] son, re [reason]; continued exit seeking behaviors daily, safety measures in place with q [every] 1 [hour] staff visualizations/checks and focus...of staff on resident's behavior. Explained if exit-seeking continues and becomes beyond capabilities of staff then they will call for family supplemental support especially with holiday weekend upcoming, [name-withheld] thanked me for calling and will be available if needed." | C1512 | | |

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| C1512 | Continued From page 7<br><br>The administration safety check history, dated 06/18/21 through 07/11/21, documented on 06/18/21 the resident was to have a visual check every hour starting at 3:00 p.m. The log revealed the safety checks scheduled for 5:00 p.m., 6:00 p.m., 7:00 p.m. and 8:00 p.m. were all signed off as done at 7:12 p.m. and did not document the resident's activity at the time of the visual safety check. The log revealed on 06/28/21, 07/03/21, 07/04/21 07/10/21 and 07/11/21 the log did not document the resident's activity at the time of the safety checks.<br><br>The log also revealed one hour monitoring was not put in place until 3:00 p.m. the next day. The interventions to prevent elopement were not immediately initiated after the incident.<br><br>The log revealed on 07/13/21 the safety checks scheduled for 12:00 a.m., 1:00 a.m. and 2:00 a.m. were all documented as done at 1:51 a.m. The log revealed the safety checks scheduled for 6:00 a.m. hourly through 10:00 a.m., were signed off as done at 10:08 a.m. The safety checks done at 11:00 a.m. hourly through 2:00 p.m. were signed off as done at 12:12 p.m. The safety checks scheduled from 5:00 p.m. hourly through 9:00 p.m. were signed off as done at 7:51 p.m.<br><br>The log documented, on 07/14/21, the safety checks were not performed at the scheduled time eighteen times and did not document the resident's activity at the time of the visual check.<br><br>The log revealed the hourly safety checks on 07/15/21 scheduled for 12:00 a.m. through 6:00 a.m. were documented as done at 5:30 a.m., the safety checks scheduled for 7:00 a.m. through 10:00 a.m. were documented as done at 10:00 a.m., and the safety checks scheduled for 11:00 | C1512 | | |

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| C1512 | Continued From page 8 | C1512 | | |

a.m., through 2:00 p.m. were documented as done at 11:43 a.m. and the scheduled checks from 3:00 p.m. through 8:00 p.m., were documented as done at 6:53 p.m.

The log revealed on 07/16/21 the hourly safety checks were not performed at the scheduled time twenty times and did not document the resident's activity at the time the visual checks were done.

The safety checks continued to be documented incorrectly from 07/17/21 through 07/20/21.

On 07/21/21 at 11:50 a.m., the LPN/director of nursing (DON) was asked if any residents were at risk for elopement. She stated yes. The LPN identified resident #1 and stated the resident was found in the parking lot. She stated the resident was on hourly safety checks and was escorted to and from meals and activities. She was asked who was responsible for doing the hourly safety checks. She stated everyone.

At 1:36 p.m., LPN #2 was asked if she was aware of any residents who had eloped. She stated yes and identified resident #1.

The LPN stated the resident had exit-seeking tendencies upon admission and continued to exit seek and at times was up all night. She stated within in the first week the resident had the front door open.

She stated in June 2021, the resident made it out of the building and to NW Expressway. She stated she was not made aware of the incident until the next afternoon.

The LPN was asked what interventions had been put in place to prevent the resident from eloping.

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| (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 |
|---|---|---|---|---|
| C1512 | Continued From page 9<br><br>She stated in March 2021 the resident was moved to an upstairs apartment. She stated the resident continued to exit seek and was placed on one hour visual safety checks the next day after she was found outside in June 2021.<br><br>At 2:17 p.m., certified nurse aide (CNA) #3 was asked if any residents were on increased monitoring. She stated yes. The CNA identified resident #1 and stated the resident liked to go outside when she was not supposed to. She stated she had gotten out once.<br><br>She was asked if she knew what to do for a missing resident. She stated she did not know the procedure but she would notify the nurse.<br><br>She was asked what she would do if the door alarm was sounding. She stated she would turn the alarm off and look to see if anybody went in or out of the door.<br><br>At 2:34 p.m., certified medication aide (CMA) #4 was asked if any residents were on increased monitoring. She stated yes and identified resident #1. The CMA was asked if resident #1 wandered. She stated yes. She stated before she was on one hour checks she roamed in the halls and she would have to go find her at times.<br><br>At 3:28 p.m., CMA #5 was asked if any residents were monitored frequently. She stated yes and identified resident #1. The CMA stated the resident was on two hour checks because she wandered sometimes.<br><br>On 07/22/21 at 2:15 p.m., CMA #2 was asked if she found resident #1 outside. She stated yes. The CMA stated she was taking out the trash and then was going to go smoke. She stated when | C1512 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL0905 | A. BUILDING: _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE ASSISTED LIVING | 9025 NW EXPRESSWAY YUKON, OK 73099 |

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|---|---|---|---|---|
| C1512 | Continued From page 10 | C1512 | | |

she turned around after taking out the trash, she saw resident #1 outside. The CMA stated she called for help immediately.

The CMA was asked how the resident got out of the building. She stated the resident went out of the door by the dining room. She stated she could not hear the door alarm sounding from the nurse's station. The CMA was asked how long the resident had been outside. She stated she did not know.

At 2:35 p.m., CMA #6 stated she worked the evening the resident was found outside. She stated she was at the nurses's station and could not hear the door alarm from inside the building. She stated when she went outside, she heard the alarm. The CMA was asked how long the resident had been outside. She stated she did not know.

She was asked if the resident could operate the elevator independently. She stated yes. The CMA was asked if the resident had wandered since the incident. She stated yes.

At 2:52 p.m., CNA #7 stated she worked the evening the resident was found outside. She stated she could not hear the door alarm from inside the building and did not know how long the resident had been outside.

At 3:08 p.m., the LPN/DON was asked when the one hour safety checks and escorts to meals and activities was implemented. She stated on 06/18/21.

The LPN/DON was asked how she ensured the resident safety checks were completed. She stated the staff documented the checks in the

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|---|---|---|---|
| | AL0905 | A. BUILDING: _____ B. WING _____ | C 07/28/2021 |

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| HERITAGE ASSISTED LIVING | 9025 NW EXPRESSWAY YUKON, OK 73099 |

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|---|---|---|---|---|
| C1512 | Continued From page 11<br>computer. She reviewed the documentation and stated, it appeared the staff had not documented the checks at the correct times.<br><br>The LPN/DON was asked if they determined how long the resident had been outside. She stated no. She was asked to activate the door alarm on the door the resident exited the building. The door was opened by the LPN/DON. The door alarm could not be heard from the nurse's station and could not be heard from the north end of the building upstairs. | C1512 | | |
| C1914 SS=D | 310:663-19-1(d) REPORTS TO THE DEPARTMENT<br><br>(d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, it was determined the center failed to submit an incident report for a missing resident to the Oklahoma State Department of Health (OSDH) for one (#1) of one resident who had exited the center without staff knowledge.<br><br>The center identified 68 residents who resided at the center.<br><br>Findings: | C1914 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | AL0905 | A. BUILDING: _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| C1914 | Continued From page 12<br><br>The center's policy titled, "Heritage Assited Living Abuse/Neglect Policy," documented, "...For the Reporting and Prevention of Resident Abuse, Neglect and Exploitation...Following is a list of incidents reportable to the Oklahoma State Department of Health...Missing Resident...The Administrator or Director of Nursing and any other appropriate staff member will investigate incidents and report to the appropriate authorities..."<br><br>Resident #1 was admitted to the center on 03/08/21 with a diagnosis of dementia.<br><br>An in-house incident/accident report, dated 06/17/21 at 8:00 p.m., documented, "...staff went to take trash out, came back looked-up and saw resident on easement of NW Expressway, apparently exited side emergency door..." The report documented the resident was oriented to self only.<br><br>On 07/22/21 at 2:15 p.m., certified medication aide (CMA) #2 was asked if she filled out the in-house incident report. She stated yes.<br><br>The CMA stated on 06/17/21 at 8:00 p.m., she took out the trash and was going to smoke. She stated when she turned around she saw the resident outside.<br><br>The CMA stated she called for staff to assist her in getting the resident to come back in the building. The CMA was asked how long the resident had been outside. She stated she did not know. She stated she could not hear the door alarm from inside the center.<br><br>At 3:08 p.m., the licensed practical nurse | C1914 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| C1914 | Continued From page 13<br>(LPN)/director of nursing (DON) was asked if she submitted an incident report for the missing resident. She stated no. She stated LPN #2 should have submitted the report to the OSDH. | C1914 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** Curtis@HeritageOKC.com

October 7, 2021

License Number: AL0905

Mr. Curtis Aduddell, Administrator
Heritage Assisted Living
9025 Nw Expressway
Yukon, OK 73099

**Survey Event ID: 6RKC11**

Dear Mr. Aduddell:

On **July 28, 2021,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 10, 2021**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.10.07 07:58:03 -05'00'

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

enc

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL0905 | A. BUILDING: _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HERITAGE ASSISTED LIVING | 9025 NW EXPRESSWAY YUKON, OK 73099 |

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| C 000 | INITIAL COMMENTS<br><br>An abbreviated survey was conducted on 07/21/21 through 07/23/21 and 07/28/21 to investigate complaint #OK00057424.<br><br>Total residents: 68 | C 000 | | |
| C1512 SS=J | 310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect<br><br>Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B<br><br>63 O.S. 1-1918.(B)(12)<br>(12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;<br><br>Title 43A O.S. 10-103. Definitions<br>8. "Abuse" means causing or permitting:<br>a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint | C1512 | Plan of Correction is being submitted using the optional template. | |

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 10/5/2021**<br>**Facility Name:** Heritage Assisted Living Center<br>**License Number:** AL0905-0905<br>**Survey Event ID:** 6RKC11<br>**Date Survey Completed: 7/28/2021** |
|---|---|

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: 1512 | Based on: observation, interview and record review, it was determined the center failed to: ensure safety alarm on an exit door could be heard throughout the inside of the building; provide supervision to prevent elopement for a cognitively impaired resident with exit-seeking behavior; and implement interventions to prevent elopement for a resident with a history of elopement and exit seeking behavior for one (#1) of one sampled resident who was identified as an elopement risk. The center identified one resident who was an elopement risk and six residents who were oriented to self only. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

| REQUIRED ELEMENTS OF A PLAN | ASSISTED LIVING CENTER'S PLAN ELEMENTS |
|---|---|
| 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? | Resident was switched from two hour safety checks to one hour safety checks until new door alarms were installed. They are now installed and can be heard from the nurses station. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | Residents that are confused and have a propensity to wander. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? | New door alarms were installed that can be heard from the nurses station. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Door alarms will be checked as part of our annual inspection and testing.<br><br>Stood at nursing station when alarms sounded and established that they could be heard.<br><br>Add to QA as a problem to monitor.<br><br>QA |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 9/10/2021 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature**<br>OAC 310:663-25-4(F) | Administrator signature required. | **Date 10/5/2021** |
|---|---|---|

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

| **Addendum Date** | Enter a date of addendum. | **Submitted by** | Enter name of person submitting addendum. |
|---|---|---|---|

Items Below Are For OSDH Use Only

| Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor |
| --- |
| If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.<br>Facility in Compliance by: Click here to enter a date. |

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

**OPTIONAL PLAN OF CORRECTION TEMPLATE**

**Current Date: 9/27/2021**
**Facility Name:** Heritage Assisted Living Center
**License Number:** AL0905-0905
**Survey Event ID:** 6RKC11
**Date Survey Completed: 7/28/2021**

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: 1914 | Based on: interview and record review, it was determined the center failed to submit an incident report for a missing resident to the Oklahoma State Department of Health (OSDH) for one (#1) of the resident who had exited the center without staff knowledge. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

| REQUIRED ELEMENTS OF A PLAN | ASSISTED LIVING CENTER'S PLAN ELEMENTS |
|---|---|
| 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? | DON inserviced all Nurses on the reporting procedure and or RN consultant is reviewing all incidents. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | Any resident who has a reportable incident as established by the OSDH or by our policy. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? | RN Consultant is reviewing every incident and making sure all incident reports that areto be reported are reported. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | This review is a permanent duty for the RN Consultant.<br>QA<br>Add to QA as a problem to monitor.<br>QA |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 9/9/2021 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

**Administrator's Signature** Administrator signature required.
OAC 310:663-25-4(F)

**Date 10/5/2021**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

| **Addendum Date** | Enter a date of addendum. | **Submitted by** | Enter name of person submitting addendum. |
|---|---|---|---|

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

**Delivery via email to:** Curtis@HeritageOKC.com; heritageassisted@gmail.com

December 19, 2022

**7021 2720 0002 0354 1372**

License Number: AL0905

Mr. Curtis Aduddell, Administrator
Heritage Assisted Living
9025 Nw Expressway
Yukon, OK 73099

**Survey Event ID: 6RKC12**

Dear Mr. Aduddell:

A revisit conducted **December 13, 2022**, revealed that your facility corrected deficiencies effective **September 10, 2021**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure:

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 |
|---|---|---|---|
| | AL0905 | A. BUILDING: _____ B. WING _____ | R-C 12/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE ASSISTED LIVING | 9025 NW EXPRESSWAY YUKON, OK 73099 |

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|---|---|---|---|---|
| {C 000} | INITIAL COMMENTS<br><br>A revisit was conducted on 12/13/22. The facility was in substantial compliance. | {C 000} | | |

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