OKLAHOMA
State Department
of Health

Delivery via email to: hgt-ed@12oaks.net

July 3, 2024

License Number: AL1101

Ms. Carla Gay, Administrator
Heritage Grove At Tahlquah Assisted Living
1380 N Heritage Lane
Tahlequah, OK 74464

RE: Survey Event ID: 9YB511

Dear Ms. Gay:

On **June 19, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **June 19, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 (attached). 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 Services**, then **click on Long Term Care.** 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 and monitoring will be completed for each violation;
(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 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, conducted in a face-to-face, or virtual 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.

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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1101	A. BUILDING: _____ B. WING _____	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE GROVE AT TAHLQUAH ASSISTED LIVING	1380 N HERITAGE LANE TAHLEQUAH, OK 74464

(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
C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/17/24 through 06/19/24. Facility Census: 37 Listed below are abbreviations that will be used throughout this document: #- Number O2- Oxygen RCC- Resident Care Coordinator RN- Registered Nurse	C 000		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's physician for four (#5, 6, 8, and #9) of nine sampled residents whose assessments were reviewed. The Executive Director identified 37 residents resided in the facility. Findings: 1. Resident #5 was admitted to the facility on 10/03/23. Resident #5's preadmission resident assessment,	C 542		

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C 542	Continued From page 1 dated 09/28/23, did not document the assessment had been coordinated and signed by an RN or the Resident's physician. 2. Resident #6 was admitted to the facility on 05/31/14. Resident #6's annual resident assessment, dated 06/07/24, did not document the assessment had been coordinated and signed by an RN or the Resident's physician. 3. Resident #8 was admitted to the facility on 01/17/24. Resident #8's preadmission/14 day resident assessment, dated 06/17/24, did not document the assessment had been coordinated and signed by an RN or the Resident's physician. 4. Resident #9 was admitted to the facility on 05/18/24. Resident #9's preadmission resident assessment, dated 04/27/24, did not document the assessment had been coordinated and signed by an RN or the Resident's physician. On 06/18/24 at 11:00 a.m., the RCC was asked to review Resident #5,6,8, and #9 above resident assessments and asked did the assessment contain a signature from a RN or resident physician, they stated "No, they are not signed."	C 542		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the	C 543		

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HERITAGE GROVE AT TAHLQUAH ASSISTED LIVING	1380 N HERITAGE LANE TAHLEQUAH, OK 74464

(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
C 543	Continued From page 2 person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident assessments contained a signature of resident or representative interview for four (#1, 6, 7, and #8) of nine sampled residents whose assessments were reviewed. The Executive Director identified 37 residents resided in the facility. Findings: 1. Resident #1 was admitted to the facility on 04/18/24. Resident #1's preadmission resident assessment, dated 03/18, did not document the assessment had been signed by resident or representative interviewed. 2. Resident #6 was admitted to the facility on 05/31/14. Resident #6's annual resident assessment, dated 06/07/24, did not document the assessment had been signed by resident or representative interviewed. 4. Resident #7 was admitted to the facility on 1/15/23.	C 543		

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	AL1101	A. BUILDING: _____ B. WING _____	06/19/2024

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C 543	Continued From page 3 Resident #7's preadmission resident assessment, dated 01/11/23, did not document the assessment had been signed by resident or representative interviewed. 3. Resident #8 was admitted to the facility on 01/17/24. Resident #8's preadmission/14 day resident assessment, dated 06/17/24, did not document the assessment had been signed by resident or representative interviewed. On 06/18/24 at 11:00 a.m., the RCC was asked to review Resident #1,6,7, and #8 above resident assessments and asked did the assessment contain a signature from the resident or representative interviewed, they stated "No, they are not signed	C 543		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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 63 O.S. 1-1918.(B)(5) (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 the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can	C1505		

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	AL1101	A. BUILDING: _____ B. WING _____	06/19/2024

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C1505	Continued From page 4 understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the center failed to secure portable oxygen tanks for 1 (#8) of 2 resident who used portable oxygen tanks when leaving their room. The Executive Director identified 37 residents resided in the facility. Findings: A "Guidelines for the Use of Oxygen" policy, undated, read in part, "...store and transport oxygen cylinders in a manner that prevents them from tipping, falling or rolling..." Resident #8 had diagnosis which included chronic obstructive pulmonary disease, Alzheimer's.	C1505		

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	AL1101	A. BUILDING: _____ B. WING _____	06/19/2024

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HERITAGE GROVE AT TAHLQUAH ASSISTED LIVING	1380 N HERITAGE LANE TAHLEQUAH, OK 74464

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C1505	Continued From page 5 A "Resident Assessment Form" dated 06/17/24, included special treatments which included continuous flowing oxygen. On 06/18/24 at 8:45 a.m., the Administrator observed with resident #8 in room,seven small free standing full oxygen tanks. The Administrator was asked are the small O2 tanks sitting on the hardwood floor properly secured, they stated, "No they are not."	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: Carla Gay <hgt-ed@12oaks.net>

July 16, 2024

License Number: AL1101

Ms. Carla Gay, Administrator
Heritage Grove At Tahlquah Assisted Living
1380 N Heritage Lane
Tahlequah, OK 74464

RE: Survey Event 9YB511

Dear Ms. Gay:

On **June 19, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. 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 **July 10, 2024**.

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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/11/2024** **Facility Name:** Heritage Grove at Tahlequah **License Number:** AL1101 **Survey Event ID:** 9YB511 **Date Survey Completed: 6/19/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542 C 543	Based on: C 542: This rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident assessments were coordinated and signed by a registered nurse or the residents physician for four (#5, 6, 8, and #9) of nine sampled residents whose assessments were reviewed. C 543: This rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident assessments contained a signature of resident or representative interview for four (#1, 6, 7, and #8) of nine sampled residents whose assessments were reviewed.

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?	C 542: ED or designee shall verify that all assessments are current and completed with required RN or physician signatures. Corrected on 7/10/2024 C 543 ED or designee shall verify that all assessments are current and completed with required family or resident interview signatures. Corrected on 7/10/2024
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	C 542: ED or designee shall verify that all assessments are current and completed with required RN or physician signatures. Corrected on 7/10/2024 C 543 ED or designee shall verify that all assessments are current and completed with required family or resident interview signatures. Corrected on 7/10/2024
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?	C 542: ED or designee shall monitor resident charts for the presence of required signatures to stay in compliance upon move in for every move in. ED or designee shall monitor all annual and/or significant change assessments for the presence of required signatures to remain in compliance monthly for one quarter and quarterly thereafter. C 542: ED or designee shall monitor resident charts for the presence of required signatures to stay in compliance upon move in for every move in. ED or designee shall

	monitor all annual and/or significant change assessments for the presence of required signatures to remain in compliance monthly for one quarter and quarterly thereafter.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	C 542: ED or designee shall monitor resident charts for the presence of required signatures to stay in compliance upon move in for every move in. ED or designee shall monitor all annual and/or significant change assessments for the presence of required signatures to remain in compliance monthly for one quarter and quarterly thereafter. C 542: ED or designee shall monitor resident charts for the presence of required signatures to stay in compliance upon move in for every move in. ED or designee shall monitor all annual and/or significant change assessments for the presence of required signatures to remain in compliance monthly for one quarter and quarterly thereafter. C 542: ED or designee shall monitor resident charts for the presence of required signatures to stay in compliance upon move in for every move in. ED or designee shall monitor all annual and/or significant change assessments for the presence of required signatures to remain in compliance monthly for one quarter and quarterly via quality assurance meetings thereafter. C 542: ED or designee shall monitor resident charts for the presence of required signatures to stay in compliance upon move in for every move in. ED or designee shall monitor all annual and/or significant change assessments for the presence of required signatures to remain in compliance monthly for one quarter and quarterly via quality assurance meetings thereafter. C 542: ED or designee shall monitor resident charts for the presence of required signatures to stay in compliance upon move in for every move in. ED or designee shall monitor all annual and/or significant change assessments for the presence of required signatures to remain in compliance monthly for one quarter and quarterly thereafter. C 542: ED or designee shall monitor resident charts for the presence of required signatures to stay in compliance upon move in for every move in. ED or designee shall monitor all annual and/or significant change assessments for the presence of required signatures to remain in compliance monthly for one quarter and quarterly thereafter.

	ED or designee shall keep documentation for monitoring resident charts for compliance. ED or designee shall monitor monthly for one quarter and quarterly via quality assurance meeting minutes thereafter.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/10/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Carla Gay, LPN, ED OAC 310:663-25-4(F)	**Date 7/11/2024**

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/11/2024** **Facility Name:** Heritage Grove at Tahlequah **License Number:** AL1101 **Survey Event ID:** 9YB511 **Date Survey Completed: 6/19/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1505	Based on: Observation, interview, and record review, the center failed to secure portable oxygen tanks for 1 (#8) of 2 residents who used portable oxygen tanks when leaving their room.

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?	Portable oxygen tanks were replaced by a portable oxygen concentrator. Corrected on 7/2/2024
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	ED or designee shall monitor residents with new or existing oxygen orders to ensure compliance of proper storage. ED or designee shall monitor monthly for one quarter and quarterly thereafter. No other resident was affected, verified on 7/2/2024.
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?	ED or Designee shall monitor residents with new or existing oxygen orders to ensure compliance of proper storage. ED or designee shall monitor monthly for one quarter and quarterly thereafter.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED or Designee shall monitor residents with new or existing oxygen orders to ensure compliance of proper storage. ED or designee shall monitor monthly for one quarter and quarterly thereafter. ED or Designee shall monitor residents with new or existing oxygen orders to ensure compliance of proper storage. ED or designee shall monitor monthly for one quarter and quarterly via quality assurance meetings thereafter. ED or designee shall monitor residents with new or existing oxygen orders to ensure compliance of proper storage. ED or designee shall monitor monthly for one quarter and quarterly thereafter. ED or designee shall keep documentation for monitoring proper storage for residents with portable oxygen tanks. ED or designee shall monitor monthly

	for one quarter and quarterly via quality assurance meeting minutes thereafter.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/2/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Carla Gay LPN, ED OAC 310:663-25-4(F)	**Date 7/11/2024**

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: hgt-ed@12oaks.net

August 7, 2024

License Number: AL1101

Ms. Carla Gay, Administrator
Heritage Grove At Tahlquah Assisted Living
1380 N Heritage Lane
Tahlequah, OK 74464

RE: Survey Event 9YB512

Dear Ms. Gay:

On **August 1, 2024,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 19, 2024,** have now been corrected effective **July 10, 2024.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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	AL1101	A. BUILDING: _____ B. WING _____	R 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE GROVE AT TAHLQUAH ASSISTED LIVING	1380 N HERITAGE LANE TAHLEQUAH, OK 74464

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 08/01/24. 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