OKLAHOMA
State Department
of Health

Delivery via email to: oklahomaed@harborchase.com

September 3, 2021

License Number: AL1414

Ms. Willena Ferguson, Administrator
Harborchase Of South Oklahoma City
10801 South May Avenue
Oklahoma City, OK 73170

RE: Survey Event ID: GK2V11

Dear Ms. Ferguson:

On **August 25, 2021**, agents from our office concluded an initial 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 August 25, 2021.

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 (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 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 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 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.

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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.

Sincerely,

Lisa Calvin

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1414	A. BUILDING: _____ B. WING _____	08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF SOUTH OKLAHOMA CITY	10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170

(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 An initial survey was completed on 08/18, 19, 23, 24, 25/2021. Deficient practice was cited. Census was 69. The following abbreviations may have been used in the writing of this report. COPD (Chronic Obstructive Pulmonary Disease) A-fib (Atrial Fibrillation) ED (Executive Director) DON (Director of Nursing) CNA (Certified Nursing Assistant) CMA (Certified Medication Aide) MAR (Medication Administration Record) MG (Milligram) PRN (as needed) BLE (bilateral lower extremities) lb (pound) B/P (blood pressure) FSBS (fingerstick blood sugar) U (units) BID (twice daily) TID (three times daily) Peg (Percutaneous endoscopic gastrostomy) OSDH (Oklahoma State Department of Health) po (by mouth) ml (milliliter)	C 000		
C 301 SS=E	310:663-3-1(a) SERVICE IN ASSISTED LIVING (a) An assisted living center shall not care for any resident needing care in excess of the level that the assisted living center is licensed to provide or capable of providing.	C 301		

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C 301	Continued From page 1	C 301		

This Rule is not met as evidenced by:
Based on interview and record review, it was determined the center failed to ensure one (#10) of 10 sampled residents did not exceed the care or services available according to the center's admission/retention criteria. This failed practice resulted in the potential for more than minimal harm at a pattern.
Findings:

Resident #10 was admitted on 06/26/2020 with diagnoses which included, diabetes mellitus 2, chronic kidney disease, hypertension, and dementia.

"HarborChase Residency Agreement" Dated June 26, 2020 documented, "Criteria for Admission to an Assisted Living Community...Persons not eligible for admission/retention are...4. Any person needing medications that require frequent dose adjustment, regulation and/or monitoring, e.g., diabetics receiving sliding scale insulin..."

A physicians order, dated 04/28/2021, documented a new order for sliding scale insulin, "Novolin Insulin R per sliding scale TID AC 0730, 1130, 430. 71-150=0, 151-200=2, 201-250=4, 251-300=6, 301-350=8." "Physician visit form" dated 04/08/2021 documented, "...Check glucose levels before breakfast, lunch and dinner..."

On 07/09/2021, "Physician's office visit" summary documented, "...Increase Tresiba dose to 32 units in the evening ..." Take Humulin R on this scale for breakfast, lunch and dinner: 0-150: 0 units, 151-200: 3 units, 201-250: 5 units, 251-300 6

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C 301	Continued From page 2 units, [more than] 300: 7 units. Check blood glucose level 4 times daily, before meals and at bedtime ..." A resident's MAR, dated 06/01/2021, documented "...Tresiba Flextouch 1000U/ML inject 30 units subcutaneously one time a day at bedtime..." ~The A.M. dose had no documentation for 13 of 30 doses. ~The P.M. dose had no documentation for 14 of 30 doses. Sliding scale and FSBS documentation was reviewed with the DON. She was asked if insulin was given at 9 p.m., on 07/11, 13, 14, 10, and 21 when there was no order to administer insulin at this time. She was also asked why there were blanks on 07/17, 19, 22, 23, 24, 25, and 26th for FSBS checks at 9 p.m. She stated she was unsure when or if resident got insulin administered or FSBS's were obtained. On 08/24/2021 at 3:43 p.m. resident #10's residency agreement was reviewed with the ED. She was asked if resident #10 met the discharge criteria, she stated, "yes by this she does." She was asked if there was a plan of accommodation for resident #10. She replied, no.	C 301		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997	C 911		

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C 911	Continued From page 3 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review it was determined the RN failed to ensure physician orders were followed for: ~medication administration (blood pressure and insulin administration); ~finger stick blood sugars were obtained; ~peg tube flushes were completed; ~weekly weights were obtained/recorded; and ~edema was assessed and monitored. This affected five (#1,#5,#8, #9 and #10) of 10 sampled residents reviewed for physician orders. This had the potential for more than minimal harm at a pattern. Findings: Resident # 1 Resident #1 was admitted with diagnoses which included: heart failure, COPD, hypertension, history of falls and A-fib. A physician's order, dated 08/01/2021, documented "...Treatments...bilateral lower extremities: Check edema one time a day twice weekly on Tues and Friday. If swelling greater than 2+ have medaid give as needed Lasix	C 911		

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C 911	Continued From page 4 ...Medications...Furosemide Tab 40 mg, one tablet by mouth one time a day as needed for swelling of bilateral lower extremities..." A physician's order, dated 06/01/2021, documented, "...Treatments...Check bilateral lower extremities edema one time a day if greater than 2+ direct CMA to give as Lasix...Medications...Furosemide tab 40 MG one tablet by mouth one time a day as needed for swelling of bilateral lower extremities..." A MAR dated 06/01/2021, contained no documentation that edema had been assessed on 7 of 30 days of the month. A physician's order, dated 05/01/2021, 06/01/2021, 07/01/2021 and 08/01/2021 documented, "...Weight orders...Weight one time a day every week on Monday on 7-3 shift, if greater than 10 lb. gain in one week, call physician ..." A MAR dated 08/01/2021 contained no documentation weights were obtained for the month of August 2021. A MAR dated 07/01/2021 documented three weights were not obtained. A MAR dated 06/01/2021 contained no documentation weights were obtained for the month of June 2021. A MAR dated 05/01/2021 documented three weights were not obtained. On 08/19/2021 at 11:53 a.m., resident #1's MAR's for May, June and July were reviewed with the DON. She acknowledged the weights were not obtained as ordered. On 08/23/2021 at 2:56 p.m., resident #1 was	C 911		

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C 911	Continued From page 5 observed sitting in his recliner watching television. Pleasant and alert. Edema observed to ankles bilateral. On 08/24/2021 at 3:43 p.m., resident #1's MAR for August 2021 was reviewed with the DON, she acknowledged no weights were obtained for the month of August until this day. Resident #5 Resident #5 was admitted with diagnoses which included: dysphagia, Parkinson, A-fib, hypertension, suprapubic catheter and PEG tube. A physician's order, dated 07/01/2021, documented "...04/10/2021 B/P every shift if greater than 180/100 see as needed Hydralazine order...Tube feeding orders...06/11/2021 flush peg tube with 240 cc's of water two times a day...Medications...Hydralazine tab 25 MG one tablet by mouth three times a day as needed for blood pressure greater than 180/100 for hypertension..." 1. The MAR, dated 08/01/2021, documented BP was not obtained on the 11-7 shift from 08/01/2021 thru 08/20/2021. 2. The MAR, dated 07/01/2021, documented BP was not obtained 29 of 31 opportunities on the 7-3 shift. There was no documentation for the month of July B/P's were obtained on the 11-7 shift. The MAR documented 21 of 60 BID peg tube flushes were not completed as ordered. 3. The MAR, dated 06/01/2021, documented 21 of 90 B/P checks were not completed as ordered	C 911		

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C 911	Continued From page 6 and 13 of 42 BID peg tube flushes were not completed as ordered. On 08/19/2021 at 12:41 p.m., the July MAR was reviewed with the DON. She acknowledged, there was no documentation that there was no place for B/P documentation for the 11-7 shift. 29 opportunities were missed for B/P checks on one shift, and four B/P checks were not obtained on one shift. On 08/24/2021 at 3:37 p.m., the DON acknowledged B/P checks were not completed on the 11-7 shift for the month of August 2021.. Resident #8 Resident #8 was admitted with diagnoses that included: Hypertension, diabetes mellitus 2, vascular dementia with visual disturbances. A physician's order, dated 06/01/2021, documented "...FSBS orders... 02/23/2021 FSBS two times a day at 07:30 am, 07:30 pm...Medications... Basaglar Kwikpen 100U/ML inject 30 units subcutaneously two times a day..." On 08/23 2021 at 10:00 a.m., resident #8's MAR was reviewed with the DON. She was asked why the dates were blank for FSBS's on 06/13, 25, 26, 27 and 28th and Basglar insulin administration on 06/09, 13, 25, 26, 27, and 28th. She stated, "We didn't have a weekend or evening nurse." Resident #9 Resident #9 was admitted with diagnose which included, diabetes mellitus, hyperlipidemia, depression, cerebrovascular accident and chronic kidney disease. A physician's order, dated 07/01/2021,	C 911		

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C 911	Continued From page 7 documented "...Vital signs... 06/29/2020 B/P two times a day, give clonidine 0.1 mg if systolic blood pressure greater than 160 or diastolic blood pressure greater than 100..." On 08/23/2021 at 10:11 a.m., MARS for May, June and July 2021 were reviewed for B/P checks with the DON. July MAR documented B/P checks were not completed four times. June MAR documented BP checks were not completed for eight times. May MAR documented B/P checks were not completed for eight times. The DON acknowledged the findings. Resident #10 Resident #10 was admitted with diagnoses which included, diabetes mellitus, chronic kidney disease, hypertension, and dementia. On 07/09/2021, "Physicians office visit summary", documented,...Increase Tresiba dose to 32 units in the evening...Take Humulin R on this scale for breakfast, lunch and dinner: 0-150: 0 units, 151-200: 3 units, 201-250: 5 units, 251-300 6 units, {more than} 300 7 units. Check blood glucose level 4 times daily, before meals and at bedtime..." On 08/10/2021, physician's order documented ...Carvedilol 6.25 mg one po BID, hold if HR <65 or BP < 115/65..." On 08/24/2021, at 10:52 a.m., resident's MAR dated 05/01/2021 was reviewed with the DON. "...Hydralazine tablet 25 mg, 3 tablets by mouth three times a day for hypertension, hold if systolic blood pressure < 100 or diastolic blood pressure < 50..." The DON was asked if BP checks were only done	C 911		

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C 911	Continued From page 8 twice daily instead of three times as ordered. She replied, that's what it looks like. Resident's MAR, dated 06/01/2021, documented "...Tresiba Flextouch 1000U/ML inject 30 units subcutaneously one time a day at bedtime..." ~The A.M. dose had no documentation for 13 of 30 doses. ~The P.M. dose had no documentation for 14 of 30 doses. Sliding scale and FSBS documentation was reviewed with the DON. She was asked if insulin was given at 9 p.m., on 07/11, 13, 14, 10, and 21 when there was no order to administer insulin at this time. She was also asked why there were blanks on 07/17, 19, 22, 23, 24, 25, and 26th for FSBS checks at 9 p.m. She stated she was unsure when or if resident got insulin administered or FSBS's were obtained. At 3:30 p.m., resident #10's MAR was reviewed, the DON was asked if Carvedolil 6.25 mg should have been administered on 08/14 B/P documented 110/60, 08/20 pulse documented 58, and 08/22 B/P documented 110/10. She stated "No."	C 911		
C1505 SS=F	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	C1505		

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C1505	Continued From page 9 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 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 it was determined the center failed to implement infection control practices to aid in the prevention and spread of COVID-19 by ensuring the following: ~ unvaccinated staff were tested according to facility policies;	C1505		

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C1505	Continued From page 10 ~ appropriate PPE was worn during COVID-19 testing; ~ visitors,vendors and staff were screened upon entrance to the center; ~ visitation was not suspended until the first round of outbreak testing was completed, and ~ center did not require staff, residents and visitors to don face masks while in the center. This had the widespread potential for more than minimal harm. Census was 69. Findings: "HarborChase STANDARD: HRA General Visitation Guidelines: Easing Indoor and Outdoor Visitation Restrictions revised 03/23/2021...General visitation is allowed provided your county positivity rates are less than 10% and greater than 70% of the residents in the community have been vaccinated...Sufficient staff to support monitoring and screening of visitors...Protocol...visitors must perform proper hand hygiene. They must always wear PPE properly, which includes KN95/N95 masks or surgical masks over nose and mouth, which may be offered at concierge desk...General visitation during an outbreak...Definition of outbreak-new onset of COVID-19 confirmed (i.e., a new COVID-19 case among residents or staff)...When a new case of COVID-19 among residents or staff is identified, community will immediately begin outbreak testing based on county and state recommendations and suspend all general visitation (except that required under federal disability rights law), until at least one round of community-wide testing is completed...Outbreak testing is discontinued when testing identifies no	C1505		

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C1505	Continued From page 11	C1505		

new cases of COVID-19 infection among staff or residents for at least 14 days since the most recent positive result. Communities should continue to consult with their state and local health departments when an outbreak is identified to ensure adherence to infection control precautions, and for recommendations to reduce the risk of COVID-19 transmission..."

On 08/18/2021 at 08:29 a.m., no screening was completed for COVID-19 upon entrance to the center.

The ED was asked when the facility stopped COVID screening. She replied, "We screened until March or April." She stated, "I think April 30th, we took the table down and haven't been screening since." She was asked if visitors and staff members wear masks but are not screened. She stated, "Yes." She identified four residents who had not had the COVID-19 vaccination. The ED was asked if any residents had tested positive. She replied, "One resident over the past weekend on Sunday. She stated, "PPE was put into place for staff." The ED was asked since the positive case what measures are in place to prevent and protect residents. She stated, "All employees are still having to wear masks and if anyone tells us they don't feel well, she (DON) tests them." She stated, "The residents are tested if symptomatic."

At 08:33 a.m., the ED stated, "Home office recommended stop screening around April 30th."

At 09:21 p.m., resident #2's room was observed to have PPE stored outside the door in a three drawer plastic bin. No signage was observed regarding the PPE. Staff members were observed wearing masks. Some residents were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1414	A. BUILDING: _____ B. WING _____	08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF SOUTH OKLAHOMA CITY	10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170

(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
C1505	Continued From page 12	C1505		

observed wearing masks, some were not.

At 10:31 a.m., employee #1 was asked how often he had been tested for COVID-19. He stated, "I haven't been tested here." He was asked if he was screened in when he entered the center. He stated the first couple of weeks he was here they were screening. He stated there was a letter saying vaccinated staff didn't have to wear masks but they just recently mandated we start wearing masks about two to three weeks ago. He started employment on May 6th, 2021.

At 1:40 p.m., CMA #2 was asked what the screening process was on entrance. She stated, " there isn't one." She was asked if residents get tested. She stated, "No, not since I been here."

At 2:35 p.m., the DON was asked when the last time residents or staff were tested for COVID-19. She replied, "If they are symptomatic." She was asked when staff started wearing masks again. She replied, "A week ago."

At 2:54 p.m., the DON was asked if the center followed the Oklahoma State Department Of Health guideline/recommendation grids. She was unaware of the grids.

On 08/19/2021 at 11:41 a.m., LPN #1 was observed performing COVID-19 testing on a staff member in the memory care dining room while residents were having lunch. LPN #1 only wore a surgical mask and gloves during testing.

At 11:53 a.m., the DON was asked what's the proper PPE to wear while testing for COVID-19. She stated,"Mask and gloves."

On 08/25/2021 at 11:10 a.m., the ED was asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1414	A. BUILDING: _____ B. WING _____	08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF SOUTH OKLAHOMA CITY	10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170

(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
C1505	Continued From page 13 when masks were no longer worn in the center. She replied, "May 1, 2021." She was asked what the facility policy was to start COVID-19 testing. She replied if they were showing signs or symptoms, or not feeling well. She was asked if the center tests based on percentage rate as recommended by the OSDH. She replied, "No." The HarborChase policy and procedure, dated 03/29/2021, was reviewed with the ED. She was asked if outbreak testing (second week) had been started this week. She replied, "No."	C1505		

OKLAHOMA
State Department of Health

Delivery via email to: oklahomaed@harborchase.com

September 30, 2021

License Number: AL1414

Ms. Willena Ferguson, Administrator
Harborchase Of South Oklahoma City
10801 South May Avenue
Oklahoma City, OK 73170

RE: Survey Event GK2V11

Dear Ms. Ferguson:

On **August 25, 2021**, 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 **November 1, 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: 2021.09.30 11:57:45 -05'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/17/2021** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** GK2V11 **Date Survey Completed: 8/25/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 301	Based on: interview and record review, it was determined the center failed to ensure one (#10) of 10 sampled residents did not exceed the care or services available according to the center's admission/retention criteria. This failed practice resulted in the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's finding or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance.

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?	1. A "Plan of Accomodation" for resident #10 will be prepared and updated as needed to insure resident is provided the appropriate care exceeding our admission/retention criteria.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	2. All residents within the community will be evaluated by a licensed nurse (RN/LPN) to identify residents who may have experienced a decline in their health care needs. If it is determined by the nursing evaluation the resident(s) current needs surpass the assisted living admission/retention criteria for eligibility in the community: a "plan of accommodation" for each individual will be instituted and their service plan will be updated to reflect how we will care for their residents' needs.
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?	3. Any resident who has a "change of condition" assessment during the year will be evaluated by a licensed nurse (RN/LPN) to determine if the resident still meets the admission/discharge/retention criteria for eligibility in the community either with or without a Plan of Accomodation. Additionally, any resident who has an annual assessment update will also be evaluated to insure a Plan of Accomodation will be instituted as necessary.
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	4. To insure the correction is made in a timely manner, the Executive Director and a licensed nurse will review all annual and change of condition assessments on a quarterly basis to insure a "Plan of Accomodation" is put in

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.	place for any resident who may no longer meet the admission/discharge/retention criteria in the HarborChase rental agreement. a. The correction will be evaluated for effectiveness by auditing the Medication Administration Records (MARs) and Treatment records (TRs) weekly for changes that would facilitate a Plan of Accomodation. An in-service will be held with all licensed staff for training regarding Plans of Accomodation and recogninzing signs of significant changes in the residents health. b. The weekly audits of the MARs and TRs will be reviewed for trends and documented in the Quarterly Quality Assurance minutes. Additionally the in-service with be addressed at the next QA meeting. c. A binder with all Plan of Accommodations, annual and change of condition assessments and the weekly audits will be created as evidence of meeting the admission/discharge/retention criteria provided in the HarborChase residency agreement.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/1/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willena Ferguson** OAC 310:663-25-4(F)	**Date 9/17/2021**

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/17/2021** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** GK2V11 **Date Survey Completed: 8/25/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 911	Based on: interview and record review it was determined the RN failed to ensure physician orders were followed for: medication administration (blood pressure and insulin administration); finger stick blood sugars were obtained; peg tube flushes were completed; weekly weights were obtained/recorded; and edema was assessed and monitored.This affected five (#1,#5,#8, #9 and #10) of 10 sampled residents reviewed for physician orders.This had the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's finding or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance.

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?	1. **A training in-service will be held for all licensed and non-licensed associates regarding following physicians orders as pertaining to (Res. #1) edema checks, BP checks (Res. #5, #9, #10), peg tube flushes (Res. #5), weights being taken (Res. #1), FSBS taken (Res. #8, #10), insulin administered at appropriate times (Res # 8, #10), and medications held when physicians BP perimiters indicate "hold or give" a BP/PRN medication (Res. #8, #9, #10).**
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	2. All resident records within the community will be evaluated by licensed staff (RN/LPN) to validate physicians' orders and to insure all skilled and non-skilled interventions are being followed both by the licensed (RN/LPN's) and non-licensed associates (CMA's and ACMA's).
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?	3. To insure physicians' orders are followed, the Executive Director and a licensed nurse will audit the Medication Administration Records (MARs) and Treatment records (TRs) weekly. An in-service will be held with all licensed and unlicensed associates (CNA's, CMA's and ACMA's) to insure they understand their role in providing quality care

	and that they will be held accountable for follow-through and delivery of the physicians' orders. Additionally, the pharmacy consultant will conduct a quarterly "med cart" audit per our contract.
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.	Through weekly audits of the MARS and TARS and on-going is-service training of the CNA's, CMA's and ACMA's. a. The correction will be evaluated for effectiveness by auditing the Medication Administration Records (MARs) and Treatment Records (TRs) weekly. If noted, deficient practices will be addressed with individuals as needed. Additionally the results of the pharmacy med-cart audit will reviewed by licensed associates. b. By reviewing the weekly audits and addressing performance trends of either licensed or non-licensed associates at each QA meeting and noting measures taken to insure physicians' orders followed. b. A binder noting weekly and quarterly audits, training in-services, and corrective actions taken to insure evidence of compliance will be available for review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/1/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Willena Ferguson OAC 310:663-25-4(F)	**Date 9/17/2021**

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.

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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: 9/17/2021** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** GK2V11 **Date Survey Completed: 8/25/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1505	Based on: observation, interview and record review it was determined the center failed to implement infection control practices to aid in the prevention and spread of COVID-19 by ensuring the following:~ unvaccinated staff were tested according to facility policies~ appropriate PPE was worn during COVID-19 testing;~ visitors, vendors and staff were screened upon entrance to the center;~ visitation was not suspended until the first round of outbreak testing was completed, and~ center did not require staff, residents and visitors to don face masks while in the center. This had the widespread potential for more than minimal harm. Census was 69

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's finding or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance.

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?	1. All licensed and unlicensed staff will be retrained on the HarborChase COVID-19 Infection Control Standards, including proper hand washing, cleaning/disinfecting the community, the practice and timeliness of wearing PPE, face masks and the proper screening and testing techniques for associates, visitors and guests as listed in the HarborChase Standard: Preventing the Spread of Covid-19 Respiratory Illness: Date issued 3/11/20 and revised on 7/12/21.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	2. All residents living in the community have the potential to be exposed to the Covid-19 virus, but as listed above, to prevent residents, staff and associates from being infected by the virus, all licensed and unlicensed staff will be retrained on the HarborChase Covid-19 Infection Control Standards, including proper hand washing, cleaning/disinfecting the community, the practice and timeliness of wearing PPE, face masks and the proper screening and testing techniques for associates, visitors and guests as listed in the HarborChase Standard: Preventing the Spread of Covid-19 Respiratory Illness: Date issued 3/11/20 and revised on 7/12/21.
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	3. Documented retraining of Screeners to ensure all visitors, guests, and vendors are screened upon arrival,

recur?	including tempertature checks. Associates will also be screened daily and tempertature taken at beginning and ending of shifts. Additionally, documented retraining of licensed staff in the use of proper PPE when administering the Covid-19 tests will be conducted. All current HarborChase employees are required to be vaccinated by 9/13/2021, unless the associate has an exception approved by the HarborChase VP of Health and Wellness.
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.	4. a. All staff is required to provide documentation of vaccination record which will be kept in the HR office. New hires will have to have proof of documentation of, at minimum, the first vaccine shot before they may be hired. Additionally, documented in-service training on infection control will be will be held with all employees, and screening documents will be available for audit. Several employees and managers are trained as screeners so appropriate screening can be done on all shifts at all times. All completed documents will be verified by the screener prior to the guests, visitors, or vendors entering the community. b. Copies of the re-training inservices for infection control, wearing proper PPE, and screening will be discussed at the quality assurance meeting and become a part of the permanent QA record. Additionally the State and CDC guidelines will be reviewed at each QA meeting for possible updates and/or changes. c. Proof of vaccinations for associates are kept in a binder in the HR office for review as needed. Screening records are identified monthly and stored in a filed cabinet with other COVID-19 records. In-service training is kept in the annual in-service binders and included in the QA documents.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/1/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willena Ferguson** OAC 310:663-25-4(F)	**Date 9/17/2021**

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.

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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: oklahomaed@harborchase.com

November 29, 2021

License Number: AL1414

Ms. Willena Ferguson, Administrator
Harborchase Of South Oklahoma City
10801 South May Avenue
Oklahoma City, OK 73170

RE: Survey Event GK2V12

Dear Ms. Ferguson:

On **November 23, 2021,** an offsite/paper revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your initial survey on **August 25, 2021,** have now been corrected effective **October 31, 2021.**

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

Sincerely,

Lisa Calvin

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

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1414	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF SOUTH OKLAHOMA CITY	10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170

(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 An off-site/paper revisit was conducted on 11/23/21. Credible evidence of correction was submitted for all deficiencies.	{C 000}		

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