
Delivery via email to: oklahomaed@harborchase.com; panderson@harborchase.com;
swilson@hraonline.net

December 30, 2022

License Number: AL1414

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

RE: Survey Event ID: 87BJ11

Dear Ms. Ferguson:

On **December 15, 2022**, agents from our office concluded a State Licensure survey with complaint investigations at your facility. 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 (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.

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 Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Harborchase of South OKC
Address: 10801 S May Ave
City, State, Zip: OKC, OK 73170
Provider #: AL1414
Complaint #: OK00058596
Investigation Date(s): 12/05/22-12/08/22 and 12/12/22-12/15/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The facility failed to provide services included in the contract.	US
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 12/05/2022 at 6:05 p.m.

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

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

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

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

An investigation specific to staffing and contracted services was conducted.

Incident reports were reviewed.

Weight documentation was provided.

Staff were observed on the memory care unit throughout the survey and not taking breaks together without supervision of memory care residents.

Medication administration was observed and completed in a timely manner.

Laundry, clean linens on beds were observed.

Staff were observed doing laundry.

No resident or family member complained about not receiving a shower, assistance with ADL's, being dressed or missed breakfast meal.

Staff stated they did not take breaks together. They stated laundry was done routinely Monday through Friday, Saturday and as needed on Sunday. They stated they had a laundry list, as well as, housekeeping also routinely completed laundry.

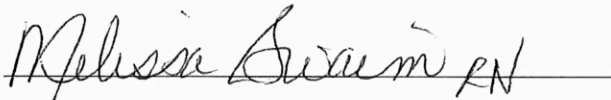
At the time of the survey, there was no deficient practice related to showers, assistance with ADL's, staffing, laundry, medication administration, or missed breakfast meal.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Melissa Swaim RN

Date report completed: 12/21/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Harborchase of S OKC
Address: 10801 S May Ave
City, State, Zip: OKC, OK 73170
Provider #: AL1414
Complaint #: OK00059839
Investigation Date(s): 12/05/22 – 12/08/22, and 12/12/22 – 12/15/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to prevent new or worsening pressure wounds.	S
2. The center failed to ensure residents received care according to nursing standards of practice, i.e., finger stick blood sugar monitoring, assistance with nourishment and hydration, and assistance with incontinent care and hygiene.	S
3. The center failed to ensure adequate staff to provide care for dependent residents.	US

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

An unannounced on-site investigation was initiated on 12/05/2022 at 6:05 p.m.

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

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 C1505 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

An investigation specific to assistance with nourishment and hydration, and assistance with incontinent care and hygiene was conducted.

Residents were observed being assisted with meals and hydration.

Residents were observed to be clean with no odors.

No resident complained, at the time of survey, about weight loss, assistance with nourishment and hydration or assistance with incontinent care or hygiene.

Staff stated they provided routine incontinent care every two hours.

At the time of the survey, there was no deficient practice related to assistance with nourishment and hydration or assistance with incontinent care or hygiene.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation related to staffing was conducted.

Staffing records were reviewed.

Staff were observed throughout the survey.

No resident complained about not having enough staff, at the time of the survey.

Staff stated they did not work alone, but with other staff.

At the time of the survey, there was no deficient practice related to staffing.

Determination Summary and Follow-Up Action:

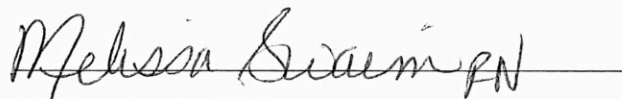
Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

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.

Deficient practice was unsubstantiated for allegation #3. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Melissa Swaim RN

Date report completed: 12/21/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/15/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SOUTH OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 A relicensure survey was conducted from 12/05/22 through 12/08/22, and 12/12/22 through 12/15/22. Complaint investigations (#OK00058596, and #OK00059839) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. ADLs-activities of daily living CKD-chronic kidney disease CMA-certified medication aide CNA-long term care aide FSBS-finger stick blood sugar LPN-licensed practical nurse MAR-medication administration record POA-plan of accommodation RN-registered nurse UTI-urinary tract infection	C 000		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to complete comprehensive assessments once every twelve months for 4 (#2, 3, 4, #6) of	C 522		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 522	Continued From page 1 twelve residents who required annual comprehensive assessments. Findings: On 12/13/22 at 11:22 a.m., during record review with RN #1, Resident #2's last comprehensive assessment was dated 07/30/21. Resident #3's last comprehensive assessment was dated 07/29/21. Resident #4's last comprehensive assessment was dated 06/21/21. Resident #6's last comprehensive assessment was dated 06/25/21. On 12/13/22 at 1:13 p.m., RN #1 stated it would be important for comprehensive assessments to be current to ensure the residents were getting the care they required.	C 522		
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 center failed to coordinate all assessments with the signature of a registered nurse or the resident's personal physician for one (#10) of twelve residents who needed an RN or personal	C 542		

Oklahoma State Department of Health

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C 542	Continued From page 2 physician to coordinate their admission comprehensive assessment. Findings: Resident #10's, comprehensive assessment, dated 11/01/22, was not signed or coordinated by an RN or their physician. On 12/15/22 at 2:07 p.m., RN #1 stated the comprehensive assessment had not been signed or coordinated by an RN or their physician.	C 542		
C 543 SS=E	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 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 center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative or the resident's personal physician and the person completing the form for two (#10 and #12) of twelve residents whose comprehensive assessments were reviewed. Findings:	C 543		

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

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C 911	Continued From page 4 Based on record review and interview, the center failed to ensure registered nurse supervision of skilled nursing interventions which included assessments, monitored skin assessments, monitored FSBS, clarification of physician orders, obtain an order for pain for 1 (#10) of 1 sampled resident who had no documentation by the registered nurse. Findings: Resident #10 admitted to the center 11/01/22 with diagnoses to include hypertension, Down's syndrome and Type II diabetes mellitus. Resident #10 was alert and oriented x 2 (person, place) with poor judgment. Only answered with yes or no answers. Fair mobility, strength, and gait. Full range of motion, weight bearing. Walked with assistance holding (both) her hands. Resident #10 needed a one person assist with bathing, dressing, transferring, toileting, and ambulation. Resident #10 was incontinent and incontinent at times of bladder. Incontinent of bowel. Resident #10 had poor ability to communicate, not interviewable, yes or no answers. Resident #10 skin condition was fair general condition, fair turgor, and described as moist. There were no abnormalities described and there were no wounds documented. A "Resident Incident Report," dated 11/09/22, read in part, "...unwitnessed fall...observed	C 911		

Oklahoma State Department of Health

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C 911	Continued From page 5 resident sitting in front of recliner with both legs under her. Reddness noted on legs..." Signed by the RN 11/10/22. A "Resident Incident Report," dated 11/13/22, read in part, "...upon entering resident's room resident was sitting on her buttocks on the floor, directly in front of recliner. Resident was full assessed..." Signed by the RN 11/14/22. A "Resident Incident Report," dated 11/14/22, read in part, "...unwitnessed fall...resident lying on R(right) side appears she slid out of chair. No injury..." Signed by the RN 11/15/22. On 12/15/22 at 1:50 p.m., RN #1 stated there was no order for barrier cream (over-the-counter.) RN #1 stated there was no record or documentation of resident (#10's) FSBS upon admission or during their stay. RN #1 stated, "I did not know how A1C (a common blood test for people with diabetes) ran." RN #1 stated resident (#10's) FSBS was not monitored. RN #1 stated the physician's orders or the physician's plan of care had not been clarified. On 12/15/22 at 3:13 p.m., RN #1 stated the family hadn't signed anything before leaving with resident (#10) who was in pain. There was not a policy for diabetics, insulin, wounds, or a respite procedure provided by RN #1 during the survey.	C 911		
C1505 SS=G	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	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 6 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 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 record review and interview, the center failed to: a) monitor finger stick blood sugars of one (#10)	C1505		

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C1505	Continued From page 7 of residents who had a diagnosis of type II diabetes mellitus; and b) prevent and monitor new wounds of one (#10) of residents who had the potential of skin breakdown with worsening wounds. Findings: A "Blood Glucose Testing" policy, read in part, "...Correct monitoring of residents' blood glucose is necessary to maintain health and well-being...Resident-owned glucose meters must be utilized when testing residents who are not able to facilitate independent testing... Treatment administered by community associates must be based on results obtained by resident-owned meters..." Exhibit 13, titled, "Statement and Explanation of Residents' Rights," read in part, "...Every resident shall have the right to receive adequate and appropriate medical care..." Exhibit 15, titled, "Criteria for Admission to an Assisted Living Community," read in part, "...Individuals seeking admission to this Community must be identified as appropriate for the level of care, services, or assistance offered...The Community shall admit and retain only those persons appropriate for placement...whose cognitive and physical needs can be met by the accommodations and services described...Persons not eligible for admission/retention are...Any person needing care of services that exceed the care or services available in the community...Any person needing treatment of stage 2, 3, or 4 decubitus ulcers, or multiple pressure sores or other widespread skin disorder...Any person needing the continuous	C1505			

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C1505	Continued From page 8 daily attention of a licensed practical nurse...residents whose conditions change to a degree that...hospitalization may be required...shall be examined by a physician..." Exhibit 16, titled, "Local Medical Transportation Policy," read in part, "...the Community shall secure or provide transportation for residents when a physician's services are needed..." The "Resident Bill of Rights," read in part, "...other belongings...Every resident shall be entitled to the possession, maintenance and use of his or her own personal...possessions...and other personal effects..." Resident #10, comprehensive assessment, dated 11/01/22, not signed or coordinated by an RN or their physician. Resident #10 had diagnoses to include essential hypertension, Down syndrome and Type 2 diabetes mellitus. A "Shift Change Communication Log," dated 11/01/22, read in part, "...New resident...Respite room...she stays in her room for all meals, but will need toileted every 2 hours and if walking her somewhere you will need to hold her hand and walk with her..." A "Shift Change Communication Log," dated 11/02/22, read in part, "...needs one on one care and it is hard to do that with only one care aid upstairs...also attached her familys requests...2 Hour checks..." A "Shift Change Communication Log," dated 11/08/22, read in part, "...2 hour checks and make sure you assist her to restroom and bed at	C1505		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SOUTH OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170		
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C1505	Continued From page 9 11 p.m...." A "Resident Incident Report," dated 11/09/22, read in part, "...unwitnessed fall...observed resident sitting in front of recliner with both legs under her. Reddness noted on legs..." Signed by the RN 11/10/22. A "Resident Incident Report," dated 11/13/22, read in part, "...upon entering resident's room resident was sitting on her buttocks on the floor, directly in front of recliner. Resident was full assessed..." Signed by the RN 11/14/22. A "Shift Change Communication Log," dated 11/13/22, read in part, "...Resident was found on the floor in front of recliner, be sure to secure paper pads under her in her chair, maybe a reason she ended up there!..." A "Resident Incident Report," dated 11/14/22, read in part, "...unwitnessed fall...resident lying on R(right) side appears she slid out of chair. No injury..." Signed by the RN 11/15/22. A "Shift Change Communication Log," not dated, read in part, "...Has pressure sore on right thigh-she is in her bed to relieve some pressure. Please check on her frequently..." A fax, dated 11/15/22, from (name-deleted) family care, read in part, "...They have noticed (name-deleted) is only sitting on the edge of the rocking chair for the past 2 weeks and they notice there are pressure sores on her thighs, one side is ope (sic) but the other has blisters, they are putting cream and foam cushioned bandages..." Bactroban oint apply to affected area bid 30 gm ordered per physician.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/15/2022
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SOUTH OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170		
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C1505	Continued From page 10 A "Shift Change Communication Log," dated 11/16/22, read in part, "...Has pressure ulcer on her R(right) thigh-please lay her down as much as possible to relieve the pressure off of her thigh. Keeping her in the chair for long hours is causing the ulcer..." Resident #10 left the center Sunday, November 20, 2022, but the November MAR documented Lantus insulin was administered through November 27, 2022 and Bactroban ointment was applied twice a day to the affected area through November 27, 2022. A hospital record, dated 11/21/22, read in part, "...Hospital problem list: Active problems: Type 2 diabetes mellitus, hypotension due to hypovolemia, UTI, Buttock wound..." Assessment, dated 11/21/22, read in part, "...pressure injury of buttock, unstageable...Reason for visit hyperglycemia, wound check..." Physical exam, dated 11/21/22, diagram, read in part, "...1. Unstageable ulcer (coccyx) 2. Unstageable ulcer (right gluteal fold)..." Hospital Course Summary, read in part, "...admitted...11/21/22...primary complaint on presentation was elevated blood sugar and concern of skin breakdown on her buttocks...At baseline she is nonverbal and has Down syndrome, hypertension, hyperlipidemia, diabetes, CKD...On admission her blood sugar was 547...Urinalysis was concerning for UTI and initial urine culture showing E. coli. She was started on Rocephin. For the skin breakdown involving the buttocks, wound care was consulted. She was place on a specialty bed...Patient's caregiver had to leave town...upon	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 11 his return on 11/18/22 he found her to be very weak and concerned about the skin breakdown on her buttocks..." A physical therapist evaluation, dated 11/22/22, read in part, "...patient nonverbal and follows minimal simple commands intermittently at baseline per chart...Right LE (lower extremity) strength (able to bear weight in static standing and be tactilly guided to take very minimal side steps)...bed/mat mobility, supine to sit, maximal assist; 2 person assist...sit to supine, maximal assist; 2 person assist...Transfers, sit to/from stand, minimal assist; moderate assist; 2 person assist...problem list, bed mobility deficits, gait deficits, social interaction deficits, transfer deficits...PT recommendation...24 hours a day at a facility or by family; Patient requires assistance for hygiene/bathing/toileting; Patient requires assistance for mobility and ADLs; Patient would benefit from therapy services 2-3 day a week..." Buttock wound, Assessment & Plan, dated 11/23/22: Wounds on both buttocks which worsened while she was in the assisted living facility. Continue repositioning and specialty bed. Continue recommendations from wound care..." A Physical Therapy Assistant note, dated 11/23/22 at 3:12 p.m., read in part, "...Pt nonverbal and unable to follow commands well enough to practice bed mobility or perform therapeutic exercise. Will return with 2nd person in order to perform mobility safely..." As of 11/25/22, appropriate to discharge the patient home with family. Will be continued on a course of ciprofloxacin to complete treatment of UTI. In regards to the patient's wounds, case management arranging home health. Current	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 12 recommendations are Dakin's wet-to dry change daily to the coccyx and left and right posterior thighs...increase her protein intake to help with healing through the use of protein shakes...Skin: Not able to logroll patient. Patient not following commands to roll over herself..." HPI, read in part, "...He had noted some erythema and skin breakdown over her buttocks prior to her being check in (to an assisted living facility). When he came back on 11/19 he found her to be very weak and also noted that the wounds on her buttocks were much worse..." A hospital record, dated 11/25/22, read in part, "...Buttock wound...Assessment & Plan: continue wound care at home and frequent repositioning. Also encouraged increased protein intake..." Resident progress note, dated 11/27/22 (sic?), read in part, "...This nurse advised to send resident to hospital for wound and pain...set up home health to eval (evaluate)/treat 11/28/22...Resident brother educated by this nurse the importance of continuing care to have a positive outcome..." On 12/12/22 at 5:50 a.m., CNA #4 stated, "We don't document." CNA #4 stated if a family member requested documentation (repositioning) they would. CNA #4 stated, "We have a communication book." At 10:22 a.m., CMA #5 stated they documented skin issues on the shower sheets and communications book. On 12/13/22 at 11:05 a.m., RN #1 stated the shower sheets completed by direct care staff were not included in the residents chart.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 13 On 12/14/22 at 10:55 a.m., CMA #1 stated they had reported skin breakdown on the right inner thigh of resident #10 Friday, November 9, 2022. CMA #1 stated it was red and blistered caused by chaffing from the diaper/pull up. CMA #1 stated it was reported to LPN #1 and LPN #2. CMA #1 stated the RN would be aware because it was included on the shower sheet documentation. CMA #1 stated the following week during shower, Tuesday, November 15, 2022 Resident #10 had a horrible wound and reported again to LPN #1 and LPN #2, but also reported to the RN and Administrator, but was told it had been reported the previous day. CMA #1 stated, "the inside was black," it was "open and draining," the "outside looked like raw skin." At 11:04 a.m., CMA #1 stated resident (#10) required two hands for walking assistance. Staff walked backwards while holding both hands of resident (#10) for transfers to toilet, shower, chair. CMA #1 stated resident (#10) did not like the chair because it was a recliner rocker resident (#10) would sit on the edge and would not lean back. CMA #1 stated resident (#10) could not express their needs. At 12:20 p.m., CNA #1 stated, "I was putting barrier cream on her." At 12:28 p.m., CNA #1 stated, "She had a sore." CNA #1 stated it started opening more (sore). CNA #1 stated, "I went to my nurse." CNA #1 stated, "Every time you wiped her she would scream." CNA #1 stated, "I know it was bad looking." At 12:48 p.m., LPN #1 stated it was difficult to care for resident (#10) because they would only	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 14 respond yes or no or with a blank stare. LPN #1 stated, resident (#10) sat on the edge of the chair. At 12:59 p.m., LPN #1 stated the personal physician for resident (#10) was contacted 11/15/22. At 1:23 p.m., LPN #2 stated resident (#10) didn't sit far enough back in the chair. When asked if were common to administer insulin without monitoring FSBS LPN #2 stated, "I didn't think anything about it since it was Lantus (long acting insulin.) LPN #1 stated it was mainly excoriation with a skin circular skin covering where a blister may have been. At 1:45 p.m., LPN #3 stated there were no treatment orders, but they had a barrier cream. LPN #3 stated, redness at the top of buttocks with a blister formation inner thigh. It opened more (the blister). LPN #3 stated resident (#10) sat on the edge of the chair and rocked which caused friction. LPN #3 stated, the blister busted (opened). LPN #3 stated, "Yes, her skin did change." At 3:03 p.m., the RN stated resident (#10) had a change in skin condition. "We did not do another skin assessment." "We should have, yes." Another skin assessment should have been documented. On 12/15/22 at 10:30 a.m., Resident #10's physician stated, "No one in assisted living informed me of anything." At 11:24 a.m., CMA #1 stated (name-deleted) cream (butt paste) was applied. CMA #1 stated a multipurpose moisture barrier ointment was	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 15 provided to apply to the affected areas. CMA #1 stated resident #10 was in pain after the area had opened. CMA #1 stated blisters and redness were noticed and reported 11/09/22. Then by 11/15/22 the area had opened, looked raw, had red and clear fluid draining from chaffing. CMA #1 stated resident (#10) stated, "Ow, ow, ow, ow, ow, ow, ow." CMA #1 stated additional pain when resident (#10) was being changed or dressing changed. At 11:42 a.m., CNA #1 stated LPN #1 provided a multipurpose moisture barrier ointment to apply. CNA #1 stated there was redness from where resident (#10) sat. CNA #1 stated, "I didn't realize there was one in the buttcheek." CNA #1 stated additional pain when resident (#10) wiped. "It hurt her." CNA #1 stated the leg part/inner thigh(s) started out red and turned into blister like she sat too long. CNA #1 stated resident (#10) stated, "Ow, ow" and "cried out." CNA #1 stated it was reported on a Monday (11/14/22). CNA #1 stated the pain lasted more than a day. CNA #1 stated, "Oh yeah, everytime you would clean her up." CNA #1 stated resident (#10) bigger in size, the brief would scratch her and hurt her, scraped her leg. CNA #1 stated resident (#10) was above level of care because you had to take it slow and easy. Resident (#10) did not initiate movement on her own. Resident (#10) had to be told what you were doing and had to be coaxed. At 12:30 p.m., LPN #1 stated resident (#10) had to be prompted to get up out of the chair. LPN #1 stated resident (#10) sat in a chair. "I never saw her move." LPN #1 stated they didn't have a physician's order to use over-the-counter cream. LPN #1 stated the physician orders had not been clarified. LPN #1 stated resident (#10) left on Sunday in pain with her brother.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 16 At 1:50 p.m., RN #1 stated there was no order for barrier cream (over-the-counter.) RN #1 stated there was no record or documentation of resident (#10's) FSBS upon admission or during their stay. RN #1 stated, "I did not know how A1C (a common blood test for people with diabetes) ran." RN #1 stated resident (#10's) FSBS was not monitored. RN #1 stated the physician's orders or the physician's plan of care had not been clarified. At 3:13 p.m., RN #1 stated the family hadn't signed anything before leaving with resident (#10) who was in pain. There was no policy for diabetics, insulin, wounds, or a respite procedure provided by RN #1 during the survey.	C1505		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure medication administration records were accurate for three (#1, 4, and #10) of 12 residents who received medication from staff at the center. Findings:	C1951		

Oklahoma State Department of Health

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C1951	Continued From page 17 Resident #1 had medication passer initials circled on their November 2022 MAR, with no explanation in the space provided on the back of the MAR. Resident #4 had medication passer initials circled on their November 2022 MAR, with no explanation in the space provided on the back of the MAR. Resident #10 had medication passer initials on their November 2022 MAR, on dates the staff stated the resident had already discharged from the center. On 12/08/22 at 11:51 a.m., CMA #7 stated the initials circled by a medication aide should have a notation on the back of the MAR with the reason a medication was not given. On 12/13/22 at 11:15 a.m., RN #1 stated they were aware of the medication passer initials circled on the MAR with no explanation on the back of the MAR. On 12/14/22 at 1:10 p.m., LPN #1 stated resident (#10) left the center the weekend before Thanksgiving. LPN #1 stated resident (#10) left the center November 20th. Any documentation after the date of 11/20/22 was misdated.	C1951		
C5020 SS=E	63 O.S. 1-890.8(F)(3)(a-d) Care and Services - POC and Follow-up 3. The person or persons responsible for performing, monitoring and assuring compliance with the plan of accommodation shall be expressly specified in the plan of accommodation	C5020		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF SOUTH OKLAHOMA CITY

10801 SOUTH MAY AVENUE
OKLAHOMA CITY, OK 73170

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/15/2022
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C5020	Continued From page 19 a) include the personal or attending physician of the resident, a home care agency, or a hospice for two (#1 and #4) as the person or persons responsible for performing, monitoring, and assuring compliance with the POA; and b) review the plan of accomodation at least quarterly for one (#4) of two residents by a licensed health care professional. Findings: On 12/13/22 at 11:07 a.m., during record review with RN #1, a) Resident #1 admitted to the center 01/28/22. Resident #1's POA was dated 08/25/22, but there was no signature space for the personal or attending physician of the resident or their hospice. Resident #4 admitted to the center 06/26/20. Resident #4's POA was dated 10/21/21, but there was no signature space for the personal or attending physician of the resident or their home health agency. b) Resident #4's POA, dated 10/21/21, had not been reviewed at least quarterly by a licensed health care professional. At 11:08 a.m., LPN #2 stated, "I thought it was one and done." At 11:09 a.m., RN #1 stated the center's POA form was missing a signature space for the personal or attending physician, hospice or a home health agency.	C5020		

Delivery via email to: oklahomaed@harborchase.com; panderson@harborchase.com;
swilson@hraonline.net

January 20, 2023

License Number: AL1414

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

RE: Survey Event 87BJ11

Dear Ms. Ferguson:

On **December 15, 2022**, agents from our office completed an Assisted Living Center survey with complaint investigations at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **ALL TAGS:** This POC has been rejected due to the correction date over 60 days from the time the letter was issued.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/13/2023	
	Facility Name: HarborChase of South Oklahoma City	
	License Number: AL1414	
	Survey Event ID: 87BJ11	
Date Survey Completed: 12/15/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 5020	Based on: record review and interview, the center failed to a) include the personal or attending physician of the resident, a home care agency, or a hospice for two (#1 and #4) as the person or persons responsible for performing, monitoring, and assuring compliance with the POA; and b) review the plan of accommodation at least quarterly for one (#4) of the two residents by a licensed health care professional.	
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. Update the Plan Of Accomodation (POA) to include both, Initial and Quarterly Review for all residents to include signature lines for 3 rd party participation in thre care of the residents: i.e. personal or attending physician, home care agency, or hospice of the two #1 and #4 as the person or persons responsible for performing, monitoring, and assuring compliance with the POA on a quarterly basis.	
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 charts with residents with a POA will be audited for compliance and updated with a new POA with proper signatures of the 3 rd party participation addressed and documented.	
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. The RN and Memory Care Director (DMC) will review all POA's once a quarter and update changes and get the proper signatures necessary whether the 3 rd party is a physiscian, home health or hospice agency.	
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. The RN will monitor the POA's and validate the need for a POA to enable the resident to age in place within the community. All POA's will be addressed at the quarterly QA meetings. a. Monthly review by the RN or DMC will provided the ED once a quarter with a face sheet identifying initial or new charts.	

		b. The monthly reviews of the POA will become a documented item in the QA meetings c. Monthly Audits will become a part of the quarterly QA process as evidence of the success of the protocol put in place to ensure the proper documentation in compliance with this rule.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Willena Ferguson OAC 310:663-25-4(F)		Date 1/13/2023	
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: 1/13/2023	
	Facility Name: HarborChase of South Oklahoma City	
	License Number: AL1414	
	Survey Event ID: 87BJ11	
Date Survey Completed: 12/15/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C522	Based on: Based on record review and interview, the center failed to complete comprehensive assessments once every twelve months for 4 (#2, 3, 4, #6) of twelve residents who required annual comprehensive assessments.	
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 the 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. An updated comprehensive assessment will be immediately completed for residents (#2,3,4, #6).
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 charts will be reviewed to determine if the comprehensive assessments have been completed timely and audited by members of the QA committee, RN, LPN, ED to insure residents annual comprehensive assessments are completed within the proper timeframe.
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 all annual comprehensive assessments are completed within the regulation timeframe, a spreadsheet will be created to review upcoming annual due dates. This report will be reviewed weekly with the RN, LPN's, and ED. If there are assessments out of compliance, assignments will be made to the LPN's and RN to update the assessments.
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 weekly comprehensive assessment review meeting during the weekly at Risk Meeting with the LPN's and RN to identify annual assessments due will be held with the Executive Director (ED). The ED will provide a master audit sheet of all assessments showing when the annual assessment is due and hold the licensed staff accountable for insuring timely completion of annual comprehensive assessments. a. Once a master audit sheet is created, assignments will be given to the clinical staff to complete annual due assessments on a weekly

		basis. The ED will verify weekly the assigned comprehensive assessments have been updated as required. b. The weekly report along with a list of completed assessments will be presented to the QA committee and reviewed against the master audit sheet. c. The audit sheets will become a permanent record with the QA meetings.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Willena Ferguson OAC 310:663-25-4(F)		Date 1/13/2023	
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			
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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/13/2023	
	Facility Name: HarborChase of South Oklahoma City	
	License Number: AL1414	
	Survey Event ID: 87BJ11	
Date Survey Completed: 12/15/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C542	Based on: record review and interview, the center failed to coordinate all assessments with the signature of a registered nurse or the resident's personal physician for one (#10) of twelve residents who needed an RN or personal physician to coordinate their admission comprehensive assessment.	
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 the 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. The updated comprehensive was finalized by the RN for resident number (#10) a respite stay, and included in the residents file.
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 comprehensive assessments in the community will be audited by members of the QA committee, RN, LPN, ED to insure residents annual comprehensive assessments are completed within the proper timeframe by the RN and attested to being complete by evidence of the RN's or Physician's signature within 14 days of the residents arrival..
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 all comprehensive assessments are completed and reviewed by the RN/PHYSICIAN within the regulation timeframe, a spreadsheet will be created to review either initial or upcoming annual due dates and reviewed weekly to insure the RN/Physician has participated in the initial or annual assessment.
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 weekly comprehensive assessment review meeting to identify initial and/or annual comprehensive assessments due with the RN's or Physician signature noting participation in comprehensive assessment. a. Once a master audit sheet is created, annual assignments will be given to the clinical staff to complete initial and/or annual due assessments on a weekly basis including having the RN or Physician's signature. The master audit sheet will

		be incorporated into the QA meetings. b. The weekly report along with a list of completed assessments with the RN/Physician signature will be presented to the QA committee and reviewed against the master audit sheet. c. The audit sheets will become a permanent record with the QA meetings.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Willena Ferguson OAC 310:663-25-4(F)		Date 1/13/2023	
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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/13/2023	
	Facility Name: HarborChase of South Oklahoma City	
	License Number: AL1414	
	Survey Event ID: 87BJ11	
Date Survey Completed: 12/15/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C543	Based on: record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative or the resident's personal physician and the person completing the form for two (#10 and #12) of twelve residents whose comprehensive assessments were reviewed.	
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 the 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. Resident #10 responsible party refused to sign the comprehensive assessment and resident #12 was a 7-day respite stay who was able to move to her new home in MS before the RN could note the completed face to face interview with the responsible party prior to them leaving.
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 comprehensive assessments in the community will be audited by members of the QA committee, RN, LPN, ED to insure residents initial and annual comprehensive assessments are completed with a face to face interview with either the resident (if applicable) or the responsible party, and attested to being complete by evidence of the RN's and the resident's or responsible party's signature within 14 days of the residents arrival or annual review date.
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 all comprehensive assessments are completed and reviewed by the RN/PHYSICIAN within the regulation timeframe, a spreadsheet will be created to review either initial or upcoming annual due dates and reviewed weekly to insure the RN/Physician has participated in the initial or annual assessment.
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;		4. A weekly comprehensive assessment review meeting to identify initial and/or annual comprehensive assessments due with the RN's and the resident or responsible party signature noting face-to-face interview in comprehensive assessment.

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.	a. Once a master audit sheet is created, initial comprehensive assessment assignments will be given to the licensed staff to complete along with the annual due assessments on a weekly basis including having the face-to-face interviews with the resident or responsible party for the resident and the RN or Physician's signature. The master audit sheet will be incorporated into the QA meetings noting the comprehensive assessment is complete. b. The weekly report along with a list of completed assessments including the face-to-face interview, RN/Physician and resident/responsible party signature will be presented to the QA committee and reviewed against the master audit sheet. c. The audit sheets will become a permanent record with the QA meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Willena Ferguson OAC 310:663-25-4(F)	Date 1/13/2023
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Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/13/2023

Facility Name: HarborChase of South Oklahoma City

License Number: AL1414

Survey Event ID: 87BJ11

Date Survey Completed: 12/15/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 911

Based on: record review and interview the center failed to ensure registered nurse supervision of skilled nursing interventions which included assessments, monitored skin assessments, monitored FSBS, clarification of physician orders, obtain an order for pain for 1 (#10) of 1 sampled resident who had no documentation by the registered nurse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Resident #10 was a respite resident and had returned home from the residence prior to the survey. No future resident (even temporary) will be admitted without orders for FSBS if the potential resident has a diagnosis of type II diabetes mellitus. Best RN nursing practice will override the responsible party and the physician plan of care who says they do not do FSBS. All face-to-face assessments of residents with a diagnosis of type II diabetes mellitus will be conducted by the RN and noted in the residents' notes.

2. The RN will review all medical records of residents who have a diagnosis of type II diabetes mellitus to insure there are no wounds and note the resident record of her findings. The RN will in-service direct care staff for proper documentation (i.e shower sheets) and follow up by physically checking the resident and document resident files as needed.

3. The RN will review both training modules on Pressure Injuries: Assessment, Interventions, Prevention and Preventing Pressure Injuries (Relias) and review the modules with all staff to insure understanding and compliance.

4. Identified wounds by direct care staff will be immediately reported to the LPN's and RN for indepth evaluation and documentation by licensed staff with referrals made to home health for appropriate wound care

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.		treatment, as needed. A weekly review of residents at risk of developing or worsening wounds will be documented in the nurses notes with referrals for the appropriate treatment as needed a. Daily review and documented care by licensed staff once a wound has been identified. b. Resident's who received or are receiving care for wounds will be discussed in QA meetings identifying the protocols in place for care and what is being done to prevent future wounds. c. All certificates for mandatory training of direct care and licensed staff will be included with the QA minutes. Residents receiving wound care will be documented in the QA minutes showing protocol in place and length of time resident required wound care.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Willena Ferguson OAC 310:663-25-4(F)		Date 1/13/2023	
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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/13/2023	
	Facility Name: HarborChase of South Oklahoma City	
	License Number: AL1414	
	Survey Event ID: 87BJ11	
Date Survey Completed: 12/15/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 1505	Based on: record review and interview the center failed to: a) monitor finger stick blood sugars of one (#10) of residents who had a diagnosis of type II diabetes mellitus; and b) prevent and monitor new wounds of one (#10) of residents who had the potential of skin breakdown with worsening wounds.	
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. Resident #10 was a respite resident and had returned home from the residence prior to the survey. No future resident (even temporary) will be admitted without orders for FSBS if the potential resident has a diagnosis of type II diabetes mellitus. Best nursing practice will override the responsible party and the physician plan of care who says they do not do FSBS.
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. The medical records of all residents who have a diagnosis of type II diabetes mellitus will be audited to insure there is a physician-ordered FSBS in place and the resident is free of wounds or is on a wound care treatment plan with the appropriate wound care provider.
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. All Direct Care and licensed staff will be required to review training modules on Pressure Injuries: Assessment, Interventions, Prevention and Preventing Pressure Injuries (Relias) to insure they can recognize potential development of pressure injuries, and what to do for existing injuries.
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		4. Identified wounds by direct care staff will be immediately reported to the LPN's and RN for indepth evaluation and documentation by licensed staff with referrals made to home health for appropriate wound care treatment, as needed. a. Weekly review and documented care by licensed staff once a wound has been identified.