OKLAHOMA
State Department
of Health

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

April 23, 2024

License Number: AL1414

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

Survey Event ID: VBO611

Dear Ms. Ferguson:

On **April 4, 2024**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

(6) Be signed by the administrator.

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

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

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies. If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste.1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

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

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Harborchase of S OKC**
Address: **10801 S May Ave**
City, State, Zip: **OKC, OK 73170**
Provider #: **AL1414**
Complaint #: **OK00063512**
Investigation Date(s):04/01/24 – 04/04/24

ALLEGATION(S)

The assisted living center neglected to provide the resident with routine pain medication as ordered by the physician.

An unannounced on-site investigation was initiated 04/01/2024 at 1:30 p.m.

A sample of 3 residents, including any identified residents, 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 Summary of Complaint Investigation:

An investigation related to physician ordered medications, incident reports, investigations, staffing schedules, medication administration records, medication refills and delivery, and resident records was conducted.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/05/2024

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 _____	C 04/04/2024

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 A complaint investigation (#OK00063512) was conducted 04/01/24 through 04/04/24. Resident census was 109. Listed below are abbreviations that will be used throughout this document. A - am - ante meridiem - before midday AL - assisted living BID - twice a day CMA - certified medication aide DC - discontinue MAR - medication administration record MC - memory care mg - milligrams ml - milliliters ODH - Oklahoma Department of Health PRN - as needed	C 000		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can	C1505		

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	AL1414	A. BUILDING: _____ B. WING _____	C 04/04/2024

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

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C1505	Continued From page 1 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 interview and record review, the center failed to administer physician ordered antipsychotic medication for one (#1) of one resident who received 10 mg of Haldol for seven days instead the prescribed 1 mg dose. Findings: A "Resident Medication Supervision" policy, not dated, read in part, "...Medications may be supervised for Residents who are unable...by a trained associate in accordance with state regulations, Nurse Practice Act, and with an order from their physician...the release or disposal of discontinued, out dated, or expired medications will be documented on the Medication Release/Disposal Record..."	C1505		

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	AL1414	A. BUILDING: _____ B. WING _____	C 04/04/2024

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

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C1505	Continued From page 2 A "Pharmacy Services/Non-Unit Dose" policy, not dated, read in part, "...The goal...is to consistently provide safe, efficient, timely and quality medication services as prescribed by the resident's physician and in partnership with the dispensing pharmacy..." A "Medication Audit" policy, not dated, read in part, "...Who should have a medication audit: All residents receiving medication management...services...match the resident's physician medication orders to their MARs. Both must match exactly...list the resident's name and apartment number and note no discrepancies found or list discrepancies between physician orders and MARs that requires physician clarification..." A "Physician's Progress Note," dated 02/28/24, read in part, "...On 02/27/24, I was notified the patient had been receiving 10 mg of Haldol as opposed to the 1 mg Haldol, which I ordered months ago...it is unclear how the mistake happened...the patient has been on 10 mg seven days from yesterday, 02/27/24...nontheless a medication error...the DON...investigating...where the problem came from..." A "Physician's Order," dated 02/28/24, read in part, "...DC 10 mg Haldol...Haloperidol 2 mg BID-start 3/3/24..." On 04/04/24 at 3:25 p.m., LPN #2 stated the medication error occured after a medication card of Haldol 10 mg was sent from a Hospice pharmacy. LPN #2 stated the medication error was caught when resident #1 was moved from AL to MC when their medication was being transferred.	C1505		

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 _____	C 04/04/2024

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

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C1512	Continued From page 3	C1512		
C1512 SS=G	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult;	C1512		

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 _____	C 04/04/2024

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

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C1512	Continued From page 4 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to administer two doses of physician ordered pain medication (morphine) for 1 (#1) of one resident who was on comfort care and experienced increased pain. Findings: An "Abuse, Neglect, and Exploitation Policy," dated 12/03/12, read in part, "...committed to the prevention of...neglect..."Neglect"...conduct of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury..." A "Comprehensive Assessment," dated 11/10/2023, read in part, resident #1 "...alert and oriented x 2 (self and place), confused at times	C1512		

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 _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1512	Continued From page 5 and forgetful with fair judgment...fair mobility, strength, and gait...limited range of motion due to weakness...ambulatory with staff assistance using a walker...1 person assist with bathing, dressing, transferring, and stand by assist with ambulation...incontinent of bladder, incontinent at times of bowel used adult briefs with assist..history of agitation...hard of hearing..." A "Physician's Order," dated 03/13/24, read in part, "...morphine 20 mg/ml-give 0.25 ml orally every 4 hours routine and every 2 hours prn..." An "Incident Report," dated 03/14/24, read in part, "...allegation of neglect...at shift change...CMA #1 reviewed the MAR...missed the 12 A and 4 A morphine...proceeded to take two doses (morphine syringes) and put them in the sharps container...signed the narc count sheet and initialed on the MAR...as given the meds (morphine syringes)...upon learning of the incident...written statement from CMA #2...sharps container had the full syringes in the container..." "ODH form 718," dated 03/18/24, read in part, "...(resident #1) did experience an increase in pain during the night...required PRN pain medication along with scheduled (pain) medication...(resident #1) was crying out for help..." On 04/04/24 at 3:34 p.m., LPN #2 stated the completed ODH form 718 documented resident #1 had increased pain and cried for help.	C1512		

OKLAHOMA
State Department
of Health

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

May 22, 2024

License Number: AL1414

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

Survey Event ID: VBO611

Dear Ms. Ferguson:

On **April 4, 2024,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 1, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/9/2024** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** VBO611 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1505	Based on: record review and interview the center failed to: Administer physician ordered antipsychotic medication for one (#1) of one resident who received 10mg of Haldol for seven days instead the prescribed 1mg dose.

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. After investigation of the event, both ACMA's received disciplinary action and reviewed the Careertech Certiied Medication Aide Study Guide and the associated test with emphasis on the 7 rights of the residents.
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 CMA's and ACMA's will also review the above study guide and take the associated test which will then be reviewed as a group at an inservice. Additionally, all medication aides will have the annual skills check off documents provided by HarborChase reviewed by a licensed nurse and updated by 6-1-2024.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	3. On a quarterly basis, all Direct Care and licensed staff will be required to review training modules on Abuse and Neglect and the 7 rights associated with medication delivery.
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 assisted living center will monitor the medication techs performance by assigning a dedicated person to review Controlled medication records on a weekly basis to ensure the medication has the right dosage on MAR, the controlled sheets, and on the carts based on the physician's order. a. Weekly review of the MAR and controlled sheets verifying proper administration of medication b. Each weekly review will be discussed the following Monday at the morning stand-up meeting and addressed in a special monthly QA for a minimum

	of 6 consequetive months. c. All in-service sign in sheets for mandatory training of the direct care staff will be included in the quarterly QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/1/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willena Ferguson** OAC 310:663-25-4(F)	**Date 5/9/2024**

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/9/2024** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** VBO611 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1512	Based on: record review and interview the center failed to: administer two doses of physician ordered pain medication (morphine) for 1 (#1) of one resident who was on comfort care and experienced increased pain.

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. After investigation of the event, the CMA who was to administer the medication was disciplined and removed from the medication cart indefinitely.
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 CMA's and ACMA's will review the Certified Medicaion Study guide, take the Relias training on Aubse and Neglect and take the associated tests on both the study guide and the Relias training. Additionally, all medication aides will have the annual skills check off documents provided by HarborChase reviewed by a licensed nurse including quoting the 7 residents' rights and their training updated in the in-service file updated by 6-1-2024.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	3. On a quarterly basis, all CMA's and ACMA's will be required to review training modules on Abuse and Neglect and the 7 rights associated with medication delivery.
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 assisted living center will monitor the medication techs performance by assigning a dedicated person to review Controlled medication records on a weekly basis to ensure the medication has the right dosage on MAR, the controlled sheets, and on the carts based on the physician's order. a. Weekly review of the MAR and controlled sheets verifying proper administration and destruction of medication. Any discrepancy noted will immediately be brought to the attention of a licensed nurse for proper handling.

	b. Each weekly review will be discussed the following Monday at the morning stand-up meeting and addressed in a special monthly QA for a minimum of 6 consequetive months. c. All in-service sign in sheets for mandatory training of the direct care staff (Medication Techs) will be included in the quarterly QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/1/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willena Ferguson** OAC 310:663-25-4(F)	**Date 5/9/2024**

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

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

Items Below Are For OSDH Use Only

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

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

OKLAHOMA
State Department
of Health

FINAL DETERMINATION
USPS Tracking # 7021 2720 0002 0354 1631

June 11, 2024

License Number: AL1414

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

Survey Event ID: VBO612

Dear Ms. Ferguson:

A revisit conducted **June 7, 2024**, revealed that your facility corrected deficiencies effective **June 1, 2024**.

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

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

Respectfully,

Lisa Calvin

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

Enclosure:

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1414	A. BUILDING: _____ B. WING _____	R-C 06/07/2024

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 A revisit was conducted on 06/07/24. All deficiencies from the 04/04/24 survey were cleared.	{C 000}		

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