OKLAHOMA
State Department
of Health

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

April 16, 2024

License Number: AL1414

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

RE: Survey Event ID: R5XD11

Dear Ms. Ferguson:

On **March 15, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **March 15, 2024**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1414	A. BUILDING: _____ B. WING _____	03/15/2024

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 relicensure survey was conducted from 03/07/24 through 03/15/24. Facility Census: 112 Listed below are abbreviations that will be used throughout this document. ADLs - activities of daily living DON - director of nursing MC - memory care	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure: On 03/12/24 at 9:58 a.m., a tour of the kitchen was conducted. The following observation were made: a. the kitchen staff were not wearing hair nets in the kitchen, b. there was a film of dust, debris and hair on the bottom shelf in the kitchen where the waffle maker, soup bowls, and plates were kept, c. there was a box of baking soda in the dry storage open to air and was not dated, d. there was a container of ground cloves dated	C 391		

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 _____	03/15/2024

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 391	Continued From page 1 02/20/20, e. there was a container of ground turmeric dated 04/01/20, f. the shelving in the dry storage area had boxes stacked within two inches from the ceiling, g. there was a silver pan containing bacon in the freezer uncovered, h. there was shelving with fish on trays uncovered in the freezer, i. there was a roll of hamburger meat that had been opened and wrapped in plastic wrap undated, j. there was a package of tortillas in the freezer with a thick black substance on the package and undated, k. the cook was observed to pick bacon out of the package bare-handed. The executive director identified 112 residents resided in the facility. On 03/012/24 at 10:37 a.m., the director of hospitality was asked how they ensured the kitchen staff cleaned and maintained the kitchen in good repair. They stated staff cleaned daily and they reported maintenance concerns to the maintenance department. The director of hospitality was asked how dishes were to be stored. They stated dishes were to be stored on shelves. The director of hospitality was asked what their protocol was for wearing hair nets in the kitchen. They stated they do not require staff to wear hair nets in the kitchen. The director of	C 391		

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 _____	03/15/2024

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 391	Continued From page 2 hospitality was asked what their protocol was for labeling food products. They stated food should be labeled. The director of hospitality was asked what their protocol was for checking foods in the freezer are stored properly. They stated food items are to be dated and discarded if a residue or black substance is observed on the packaging. The director of hospitality was shown the above observations and/or the above observations discussed.	C 391		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete comprehensive assessments once every twelve months for 5 (#5, 10, 11, 31 and # 69) of 11 sampled residents reviewed for annual comprehensive assessments. Findings: Resident #5's last comprehensive assessment was dated 12/15/22. Resident #10's last comprehensive assessment was dated 01/09/23.	C 552		

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 _____	03/15/2024

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 552	Continued From page 3 Resident #11's last comprehensive assessment was dated 12/15/22. Resident #31's last comprehensive assessment was dated 09/14/22. Resident #69's last comprehensive assessment was dated 10/08/22. 03/14/24 at 9:32 a.m., the DON was asked to review the residents' chart for an annual assessment. They stated there were no annual assessments in resident charts #5, 10, 11, 31 and #69.	C 552		
C5015 SS=E	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or	C5015		

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 _____	03/15/2024

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
C5015	Continued From page 4 attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to conduct a quarterly review of the plan of accommodations for two (#5, and # 10) of 11 sampled residents reviewed for plan of accommodation. 1. The quarterly review of the last plan of accommodation for resident #5 was dated 08/01/23. The resident resides in the memory care unit. The comprehensive assessment, dated 08/25/22, documented resident #5 had a diagnoses of Lewy Body Dementia, Crohn's Disease, anxiety, and bipolar. They were confused with poor	C5015		

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 _____	03/15/2024

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
C5015	Continued From page 5 judgement. Resident #5's mobility was poor with poor strength, cognition was severely impaired, was chairfast, required a Hoyer lift with transfers, and two persons assist with most ADL's. Resident #5 ate their meals in the memory care unit dining room and required the staff to feed them. They were incontinent of bladder and bowel with total assistance and used adult briefs. They were a poor communicator; not interviewable, unable to verbalize needs. Their general condition was poor, thin, fragile with poor turgor. Resident #5's special treatments included hospice care. On 03/12/24 at 9:15 a.m., resident #5 was observed sitting in the common area listing to music accompanied by other residents and staff. On 03/12/24 at 1:12 p.m. The DON of the memory care unit was asked to review resident #5s chart for a updated quarterly plan of accommodation. They stated there was not an updated plan of accommodation in the chart. 2. The quarterly review of the last plan of accommodation for resident #10 was dated 08-01-23. The resident resides in the memory care unit. The comprehensive assessment, dated 01/09/23, documented resident #10 had diagnoses of dementia, depression, and osteoporosis. They were confused with poor judgement. Resident #10's mobility was poor with poor	C5015		

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 _____	03/15/2024

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
C5015	Continued From page 6 strength, cognition was severely impaired, was chairfast, required a Hoyer lift with transfers, and two persons assist with most ADL's. Res #10 ate their meals in the memory care unit dining room and required staff to feed them. They were incontinent of bladder and bowel with total assistance and used adult briefs. They were a poor communicator; not interviewable, unable to verbalize needs. Their general condition was poor, thin, fragile with poor turgor. Resident #10s special treatments included hospice care. On 03/12/24 at 9:18 a.m., resident #10 was observed sitting in the common are listing to music and accompanied by other residents and staff. On 03/12/24 at 1:14 p.m. The DON of the memory care unit was asked to review resident #10's chart updated for a plan of accommodation. They stated there was not an updated plan of accommodation in the chart.	C5015		

OKLAHOMA
State Department
of Health

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

April 30, 2024

License Number: AL1414

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

RE: Survey Event R5XD11

Dear Ms. Ferguson:

On **March 15, 2024,** agents from our office completed an Assisted Living Center survey 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:** The correction dates are unacceptably long. the POC date is greater than 60 days from the date the statement of deficiencies was sent to the center.

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

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: 4/26/2024** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** R5XD11 **Date Survey Completed: 3/15/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: Observation and interview it was determined the STANDARD for Food Storage, Preparation and Service (Chapter 257) was not met by: a. the kitchen staff were not wearing hairnets; b. film of dust, debris, and hair on bottom shelf where waffle maker, soup bowls, plates were kept; c-d-e-j spices/food out of date; f. boxes stacked too close to ceiling; g-h-i food uncovered on pans in freezer and k. cook observed to pick bacon out of package bare-handed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted under Federal ad State regulations and status applicable to long term care prorviders. 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.To protect all 112 residents, all open food in the freezers and foods without proper dates immediately discarded.
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. To insure all 112 residents will not be affected by the deficient practices identified; All food service employees will be immediately in-serviced on proper storage of food in accordance with Chapter 257, including the OSDH Food Handler's Training for all employees in the hospitality department. A daily walk through by Executive Director and Executive Chef to insure all storage items are displayed properly and there are no uncovered food in the cold storage.
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 dietary employees will have a documented quarterly review on proper storage of food, food handlers training, wearing gloves and hairnets
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 task sheet will be developed identifying the items found to be deficient and a director from various departments will review the list weekly and report any infractions at the Monday morning stand-up. a. Reviewed weekly by a director from another department following the task sheet provided; b. The weekly report will be incorporated into

	the QA minutes c. The task sheets will become part of the QA minutes as evidence of the ongoing inspections.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/26/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willena Ferguson** OAC 310:663-25-4(F)	**Date 4/26/2024**

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: 4/26/2024** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** R5XD11 **Date Survey Completed: 3/15/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 552	Based on: record review and interview, the facility failed to complete comprehensive assessments once every twelve months for 5 (#5, 10, 11, 31,and #69) of 11 sampled residents reviewed for annual comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted under Federal ad State regulations and status applicable to long term care prorviders. 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 annual assessment will immediatly be completed for residents (#5, 10,11,31, and #69) of the eleven sampled 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 charts will be audited to identify residents who may not have an up-to-date annual assessment and the clinical staff will bring all charts up-to-date. Members of the QA committee, RN, LPN, and ED will report to the committee the findings and measures taken to insure residents annual assessments are completed and fliled properly.
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. A spread sheet will be created to verify all residents in the community have the initial and subsequent assessments in their charts, along with a column showing when the next assessment is due. The ED will monitor the spread sheet on a monthly basis to verify there are no assessments missed.
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 with the LPN's and RN to identify annual assessments due with 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 review and complete the annual assessments. All assessments will be routed through the Director of

	Wellness (RN) and Executive Director's (ED) Office to review for completeness. 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?	6/26/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willena Ferguson** OAC 310:663-25-4(F)	**Date 4/26/2024**

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: 4/26/2024** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** R5XD11 **Date Survey Completed: 3/15/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C5015	Based on: Based on observation, interview, and record review, the facility failed to conduct a quarterly review of the plan of accommodations for two (#5 and #10) of 11 sampled residents reviewed for Plan of accommodation

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted under Federal ad State regulations and status applicable to long term care prorviders. 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 plan of accomodation will be immediatly completed for residents (#5 and #10) of the eleven sampled 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 charts will be reviewed to identify residents who have a plan of accommodation (POA). All POA's will be reviewed to determine if the documents have been updated timely (quarterly) and a copy added to their chart. Members of the QA committee, RN, LPN, and ED will report to the committee the findings and measures taken to insure residents annual POA's ae completed and fliled properly.
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 POA's are reviewed and updated quarterly, a spreadsheet will be created to review upcoming 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 reported to the LPN's and RN to ensure all Plan of Accommodations are completed timel.
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 with the LPN's and RN to identify annual assessments due with 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

	review and complete quarterly the Plan of Accommodations on a monthly 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?	6/26/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willena Ferguson** OAC 310:663-25-4(F)	**Date 4/26/2024**

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

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

Items Below Are For OSDH Use Only

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

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

OKLAHOMA
State Department
of Health

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

May 1, 2024

License Number: AL1414

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

RE: Survey Event R5XD11

Dear Ms. Ferguson:

On **March 15, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your AMENDED 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: 4/26/2024** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** R5XD11 **Date Survey Completed: 3/15/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: Observation and interview it was determined the STANDARD for Food Storage, Preparation and Service (Chapter 257) was not met by: a. the kitchen staff were not wearing hairnets; b. film of dust, debris, and hair on bottom shelf where waffle maker, soup bowls, plates were kept; c-d-e-j spices/food out of date; f. boxes stacked too close to ceiling; g-h-i food uncovered on pans in freezer and k. cook observed to pick bacon out of package bare-handed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted under Federal ad State regulations and status applicable to long term care prorviders. 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.To protect all 112 residents, all open food in the freezers and foods without proper dates immediately discarded.
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. To insure all 112 residents will not be affected by the deficient practices identified; All food service employees will be immediately in-serviced on proper storage of food in accordance with Chapter 257, including the OSDH Food Handler's Training for all employees in the hospitality department. A daily walk through by Executive Director and Executive Chef to insure all storage items are displayed properly and there are no uncovered food in the cold storage.
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 dietary employees will have a documented quarterly review on proper storage of food, food handlers training, wearing gloves and hairnets
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 task sheet will be developed identifying the items found to be deficient and a director from various departments will review the list weekly and report any infractions at the Monday morning stand-up. a. Reviewed weekly by a director from another department following the task sheet provided; b. The weekly report will be incorporated into

	the QA minutes c. The task sheets will become part of the QA minutes as evidence of the ongoing inspections.
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 5/1/2024**

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	5/1/2024	**Submitted by**	Willena Ferguson-ED

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: 4/26/2024** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** R5XD11 **Date Survey Completed: 3/15/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 552	Based on: record review and interview, the facility failed to complete comprehensive assessments once every twelve months for 5 (#5, 10, 11, 31,and #69) of 11 sampled residents reviewed for annual comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted under Federal ad State regulations and status applicable to long term care prorviders. 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 annual assessment will immediatly be completed for residents (#5, 10,11,31, and #69) of the eleven sampled 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 charts will be audited to identify residents who may not have an up-to-date annual assessment and the clinical staff will bring all charts up-to-date. Members of the QA committee, RN, LPN, and ED will report to the committee the findings and measures taken to insure residents annual assessments are completed and fliled properly.
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. A spread sheet will be created to verify all residents in the community have the initial and subsequent assessments in their charts, along with a column showing when the next assessment is due. The ED will monitor the spread sheet on a monthly basis to verify there are no assessments missed.
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 with the LPN's and RN to identify annual assessments due with 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 review and complete the annual assessments. All assessments will be routed through the Director of

	Wellness (RN) and Executive Director's (ED) Office to review for completeness. 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?	6/1/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Willena Ferguson OAC 310:663-25-4(F)	**Date 5/1/2024**

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	5/1/2024	**Submitted by**	Willena Ferguson-ed

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: 4/26/2024** **Facility Name:** HarborChase of South Oklahoma City **License Number:** AL1414 **Survey Event ID:** R5XD11 **Date Survey Completed: 3/15/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C5015	Based on: Based on observation, interview, and record review, the facility failed to conduct a quarterly review of the plan of accommodations for two (#5 and #10) of 11 sampled residents reviewed for Plan of accommodation

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted under Federal ad State regulations and status applicable to long term care prorviders. 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 plan of accomodation will be immediatly completed for residents (#5 and #10) of the eleven sampled 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 charts will be reviewed to identify residents who have a plan of accommodation (POA). All POA's will be reviewed to determine if the documents have been updated timely (quarterly) and a copy added to their chart. Members of the QA committee, RN, LPN, and ED will report to the committee the findings and measures taken to insure residents annual POA's ae completed and fliled properly.
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 POA's are reviewed and updated quarterly, a spreadsheet will be created to review upcoming 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 reported to the LPN's and RN to ensure all Plan of Accommodations are completed timel.
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 with the LPN's and RN to identify annual assessments due with 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

	review and complete quarterly the Plan of Accommodations on a monthly 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?	6/1/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willena Ferguson** OAC 310:663-25-4(F)	**Date 5/1/2024**

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	5/1/2024	**Submitted by**	Willena Ferguson-ED

Items Below Are For OSDH Use Only

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

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

OKLAHOMA
State Department
of Health

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

June 11, 2024

License Number: AL1414

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

RE: Survey Event R5XD12

Dear Ms. Ferguson:

On **June 7, 2024,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 15, 2024,** have now been corrected effective **June 1, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

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 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 03/15/24 survey were cleared.	{C 000}		

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