OKLAHOMA
State Department
of Health

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

August 7, 2024

License Number: AL1414

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

Survey Event ID: KUVY11

Dear Ms. Ferguson:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **August 2, 2024**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me 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

INVESTIGATIVE REPORT

Facility: **HARBORCHASE OF SOUTH OKLAHOMA CITY**
Address: **10801 SOUTH MAY AVENUE**
City, State, Zip: **OKLAHOMA CITY, OK, 73170**
Provider #: **AL1414**
Complaint #: **OK00066125**
Investigation Dates: **08/01/24 through 08/02/24**

ALLEGATION
The center failed to protect the resident from physical and verbal abuse

An unannounced on-site investigation was initiated 08/01/2024 at 8:53 A.M.

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

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:

A tour of the facility was conducted upon entrance, and at other various shifts throughout the survey. Staff interaction with residents were observed.

Facility policies and procedures were reviewed. Resident assessments and progress notes were reviewed. Grievances, in-services, and State reportables were reviewed.

Residents were interviewed regarding staff interactions with them. Staff were interviewed regarding the facility policies and procedures related to abuse.

The attached State form, Statement of Deficiencies, 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: 08/02/2024

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 _____	C 08/02/2024

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 (#OK00066125) was conducted from 08/01/24 through 08/02/24. No deficiencies were cited. Facility Census: 108	C 000		

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