OKLAHOMA
State Department of Health

**Delivery via email to:** andrea.donaldson@harrisonlife.com

January 8, 2025

License Number: AL1414

Ms. Andrea Donaldson, Administrator
The Harrison Of Oklahoma City Al And Mc
10801 South May Avenue
Oklahoma City, OK 73170

**Survey Event ID: 9FFK11**

Dear Ms. Donaldson:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **December 27, 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:** **The Harrison of Oklahoma City AL and MC**
**Address:** **10801 South May Avenue**
**City, State, Zip:** **Oklahoma City, OK, 73107**
**Provider #:** **AL1414**
**Complaint #:** **OK00068784**
**Investigation Date(s):** **12/23/24 and 12/27/24**

| ALLEGATION(S) |
|---|
| The facility failed to assess, monitor, and intervene in a timely manner for residents with falls which resulted in major injuries. |
| The facility failed to provide supervision to prevent accidents. |

An unannounced on-site investigation was initiated 12/23/2024 at 8:18 a.m.

A sample of six 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:**

A tour of the facility was conducted upon entrance and at other times throughout the survey. Resident halls were observed for residents in need. Staff were observed for assisting and monitoring residents.

Resident records were reviewed including assessments, service plans/plan of care, orders, nursing, and physician notes were reviewed. Grievances and incidents were reviewed. Facility policy and procedures were reviewed.

Residents were interviewed related to the provision of accidents and falls.

Staff members were interviewed regarding the facility policy for falls and accidents. They were asked what they do for residents with falls.

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: 01/07/2025

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# INVESTIGATIVE REPORT

**Facility:** **The Harrison of Oklahoma City AL and MC**
**Address:** **10801 South May Avenue**
**City, State, Zip:** **Oklahoma City, OK, 73107**
**Provider #:** **AL1414**
**Complaint #:** **OK000674635**
**Investigation Date(s):** **12/23/24 and 12/27/24**

| ALLEGATION(S) |
| --- |
| The facility failed to provide adequate supervision to prevent elopement. |

An unannounced on-site investigation was initiated 12/23/2024 at 8:18 a.m.

A sample of three 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:**

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls were observed for exit seeking residents.

Resident records were reviewed including assessments, service plan/plan of care, orders, nurse notes, progress notes. Facility policy and procedures were reviewed. Grievances were reviewed.

Residents were interviewed related to the provision of elopement and residents leaving the facility.

Staff members were interviewed regarding the facility policy for elopement and were asked if there were any elopements.

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: 01/07/2025

| 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 12/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HARRISON OF OKLAHOMA CITY AL AND MC | 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<br><br>Complaint investigations (#OK00068784 and #OK00074635) were conducted on 12/23/24 and 12/27/24. No deficiencies were cited.<br><br>Facility Census: 113 | C 000 | | |