

Delivery via email to: kbolino@sagora.com; kbolino@veradenlife.com

September 23, 2025

License Number: AL1414

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

RE: Survey Event ID: ZNQT11

Dear Ms. Bolino:

On **August 28, 2025**, 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 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 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 OSDH.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, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: The Harrison of Oklahoma City AL and MC

Address: 10801 South May Avenue

City, State, Zip: Oklahoma City, OK 73170

Provider #: AL 1414

Complaint #: OK00075736

Investigation Date(s): 08/25/25 – 08/28/25

ALLEGATION(S)

The center failed to ensure adequate supervision was provided to prevent accidents.

The center failed to assess, monitor and intervene in a timely manner for changes in condition.

The center failed to ensure assistance with activities of daily living was provided according to the contract and plan of care.

An unannounced on-site investigation was initiated 08/25/2025 at 10:50 a.m

A sample of 10 participants, including any identified participants, 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 participants, 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 admission and at other various times throughout the survey. Resident hallways, common areas and rooms were observed for accident hazards. Residents were observed for ill appearing or in need of assistance. Staff were observed to interacting and assisting residents with their needs.

Resident records were reviewed including resident assessments, care plans, orders, progress notes, and incident reports. Facility policy and procedures were reviewed.

Residents were interviewed regarding accidents, changes in their condition and staff assistance.

Staff members were interviewed regarding the facility policy and procedures.

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: 08/28/2025

INVESTIGATIVE REPORT

Facility: The Harrison
Address: 10801 South May Ave
City, State, Zip: OKC, OK 73170
Provider #: AL1414
Complaint #: OK00078709
Investigation Date(s): 08/25-28/25

ALLEGATION(S)
The facility failed to provide care and services per physicians' orders and plan of care
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 08/25/2025 at 11:00 a.m.

A sample of 10 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: Observations of residents in the center's bar area were made and records reviewed were physician orders and care plans. Interviews with staff, residents, and families were conducted. Based on observation, record review, and interview, no citations were issued based on this complaint.

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: 08/28/2025

INVESTIGATIVE REPORT

Facility: The Harrison
Address: 10801 South May Ave
City, State, Zip: OKC, OK 73170
Provider #: AL1414
Complaint #: OK00079631
Investigation Date(s): 08/25-28/25

ALLEGATION(S)
The center failed to assess, monitor and intervene in a timely manner for a resident who fell and sustained injuries
The center failed to ensure dependent residents received ADL assistance in a timely manner
The center failed to ensure call lights was answered in a timely manner
The center failed to provide residents therapeutic diets
The center failed to honor residents dietary preferences
The center failed to ensure residents' Foley catheter tubing was patent and properly positioned
The center failed to notify families/legal surrogates of a change in resident's condition

An unannounced on-site investigation was initiated 08/25/2025 at 11:00 a.m.

A sample of 10 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: Observations of residents and staff were made over several shifts and days. Observations of dining, call lights and ADL care were made. Records including, but not limited to, physician's orders, service plans, assessments, policies, and resident health records were reviewed. Interviews with staff, residents, and families were conducted. Based on observation, record review, and interview, the center failed to assess, monitor and intervene in a timely manner for a resident who fell and sustained injuries as well as failed to notify families/legal surrogates of a change in resident's condition.

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: 08/28/2025

INVESTIGATIVE REPORT

Facility: The Harrison
Address: 10801 South May Ave
City, State, Zip: OKC, OK 73170
Provider #: AL1414
Complaint #: OK00085070
Investigation Date(s): 08/25-28/25

ALLEGATION(S)
The center failed to assess, monitor and intervene in a timely manner for a change in condition
The center failed to ensure incidents were documented
The center failed to ensure adequate staff to meet the needs of the residents
The center failed to ensure palatable food was served under sanitary conditions
The center failed to ensure billing for necessary medical supplies was not falsified

An unannounced on-site investigation was initiated 08/25/2025 at 11:00 a.m.

A sample of 10 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: Observations of the kitchen, residents, and staff were made. Records of, including, but not limited to, physician's orders, incident reports, staffing documentation, policies, and contracts were reviewed. Interviews with residents, family, and staff were conducted. Based on observation, record review, and interview, the center failed to assess, monitor, and intervene in a timely manner for a change in condition, failed to ensure food was served under sanitary conditions, and failed to ensure correct billing for residents.

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: 08/28/2025

INVESTIGATIVE REPORT

Facility: The Harrison Of Oklahoma City AL and MC
Address: 10801 South May Avenue
City, State, Zip: Oklahoma City, OK, 73170
Provider #: AL1414
Complaint #: OK00085256
Investigation Date(s): 08/25/25 – 08/28/25

ALLEGATION(S)

The facility failed to ensure residents that Nutritive/Appearance/Palatable/Preferred Temperature food was served to residents.

An unannounced on-site investigation was initiated 08/25/2025 at 10:50 a.m.

A sample of 10 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 meals were observed for appearance, palatability, appearance and temperature. Residents observed how they reacted to the meal being served and the amounts eaten.

Resident records were reviewed including assessments, care plans, orders, and progress notes. The facility weekly menu was observed. Resident wt. records were reviewed for loss and or gain of weight. Facility policy and procedures were reviewed. Grievance records were reviewed.

Residents were interviewed related to the provision of food and meals. Resident were asked how their meals were

Staff interviewed regarding meal service process.

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: 08/28/2025

INVESTIGATIVE REPORT

Facility: The Harrison Of Oklahoma AL and MC
Address: 10801 South May Avenue
City, State, Zip: Oklahoma City, OK 73170
Provider #: AL 1414
Complaint #: OK00085301
Investigation Date(s): 08/25/25 – 08/28/25

ALLEGATION(S)
The facility failed to ensure adequate supervision to prevent falls.
The facility failed to ensure adequate dietary staff to serve meals.
The facility failed to notify the residents representative when the resident had fallen.
The facility failed to ensure residents were not involuntarily restrained.

An unannounced on-site investigation was initiated 08/25/2025 at 10:50 a.m.

A sample of 10 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 during the survey. Resident hallways, rooms, and common areas were observed for staff interacting with and assisting resident with their care needs. Resident were observed during meal service, sitting in their wheelchairs, and in their rooms. Residents were observed for injury and restraints.

Resident records were reviewed including resident assessments, care plans, orders, progress notes, weight records. Facility policy and procedures were reviewed.

Residents were interviewed related to the provision of meals and meal service and falls.

Staff members were interviewed regarding policy and procedure for meal service and 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: 08/28/2025

INVESTIGATIVE REPORT

Facility: The Harrison
Address: 10801 South May Ave
City, State, Zip: OKC, OK 73170
Provider #: AL1414
Complaint #: OK00085371
Investigation Date(s): 08/25-28/25

ALLEGATION(S)
The center failed to ensure care and treatment was provided according to the plan of care, level of care was not above the level the center could safely provide and assessments were completed according to regulation
The center failed to ensure medications were administered according to the physicians' orders
The center failed to ensure qualified staff completed care and treatment
The center failed to ensure adequate staff to meet the needs of the residents
The center failed to ensure adequate/qualified kitchen staff to provide meals according to the scheduled times
The center failed to provide necessary supplies (gloves) to ensure an effective infection control program

An unannounced on-site investigation was initiated 08/25/2025 at 11:00 a.m.

A sample of 10 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: Observations of residents and staff were made as well as medication administration and ADL care. Records of, including but not limited to, physician's orders, care plans, assessments, policies, and staffing documentation and credentials were reviewed. Interviews with residents, families, and staff were conducted. Based on observation, record review, and interview the center was in compliance with state regulations regarding these allegations.

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: 08/25/2028

INVESTIGATIVE REPORT

Facility: The Harrison
Address: 10801 South May Ave
City, State, Zip: OKC, OK 73170
Provider #: AL1414
Complaint #: OK00085567
Investigation Date(s): 08/25-28/25

ALLEGATION(S)
The facility failed to ensure medications were administered according to the physician orders
The facility failed to ensure dietary staff were qualified to prepare and serve meals
The facility failed to ensure staff did not practice outside their scope of practice
The facility failed to follow physician orders to obtain labs
The facility failed to ensure resident's were not charged for services not included in their contract
The facility failed to maintain accurate clinical medical records
The facility failed to ensure the facility had a licensed administrator
The facility failed to notify resident's representatives or the physician when a resident had a change in condition
The facility failed to ensure adequate staff to provide resident care
The facility failed to ensure the resident were provided activities to meet their interest.
The facility failed to ensure dietary orders were followed according to the physician orders.

An unannounced on-site investigation was initiated 08/25/2025 at 11:00 a.m.

A sample of 10 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: Multiple observations of residents, staff, activities, food preparation, and medication administration were made. Records of, including but not limited to, physician's orders, residents' health charts, staffing credentials, resident contracts, clinical medical records, staffing documentation, and policies were reviewed. Based on observation, record review, and interview, it was determined that the facility failed to ensure correct billing per contract and notify family/legal representative of residents' change in condition.

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: 08/28/2025

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 08/28/2025
NAME OF PROVIDER OR SUPPLIER THE HARRISON OF OKLAHOMA CITY AL AND MC		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 with complaints (#OK00078709, OK00079361, OK00085070, OK00085371, and #OK00085567) was conducted from 08/25/25 through 08/28/25. Deficiencies were cited as a result of this survey. Facility Census: 88 Listed below are abbreviations that will be used throughout this document: CMA - certified medication aide CNA - certified nurse aide CPR - cardiopulmonary resuscitation ED - emergency department EMSA - emergency medical services authority ER - emergency room oz - ounce QA - quality assurance RN- registered nurse	C 000		
C 391 SS=D	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 center failed to ensure: 1. the cleaning schedule for the kitchen was followed,	C 391		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 08/28/2025
NAME OF PROVIDER OR SUPPLIER THE HARRISON OF OKLAHOMA CITY AL AND MC		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 391	Continued From page 1 2. foods were labeled, dated, and covered, and; 3. left overs were disposed of in accordance with food safety guidelines. The administrator identified 88 residents resided in the center. Findings: 1. On 08/25/25 at 11:11 a.m., the following was observed: a. The grill was black with grease, a powdery black substance scattered on the surface and the grease trap was thick with food debris and grease. b. The floor of the walk in freezer there were multiple small pieces of paper and cardboard scattered throughout as well as a white substance frozen to the floor in front of the food shelves. c. The ice machine had brown and beige residue dripping from the top of the machine, down the side, and to the floor. This same residue was on the inside of the ice machine around the lip of the lid. 2. On 08/25/25 at 11:11 a.m., the following observations were made: a. Two boxes of Quick Oats were observed to be open, exposing the food to open air. The boxes were not dated. b. A bottle of "Teriyaki sauce" was observed to have the sauce caked around the lid and on the side of the bottle, which had leaked onto the shelf. This bottle did not have a date indicated when it had been opened. c. Two 8 quart containers were each filled with 1.5 quarts of a beige substance which was	C 391		

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 08/28/2025
NAME OF PROVIDER OR SUPPLIER THE HARRISON OF OKLAHOMA CITY AL AND MC		STREET ADDRESS, CITY, STATE, ZIP CODE 10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170		
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C 391	Continued From page 2 crusted to the sides of the containers. One of the 8 quart containers was labeled, "waffles," with no date on the container. The second 8 quart container was not labeled or dated. d. An opened 32 oz container of "Liquid Whole Egg" was sitting on the shelf with no date that indicated when it had been opened. e. One small metal pan was covered with plastic wrap and labeled a, "bacon grease" with no date indicating when it was collected or stored. f. One 8 quart container with 2 quarts of a thick, white substance that had green specks inside did not have a label or a date. g. A gallon of milk, with no lid in place, was sitting on a shelf and did not have a date indicating when it had been opened. 3. On 08/25/25 at 11:31 a.m., a container labeled "cranberry sauce," dated 07/20, was observed in the refrigerator. On 08/25/25 at 12:35 p.m., it was observed the two boxes of Quick Oats had been closed. The Whole Liquid Egg, opened gallon of milk, left over cranberry sauce, and teriyaki sauce had been thrown away. The grill was still covered with stuck on substances and grease. The floor of the walk in freezer still had multiple small pieces of paper and cardboard scattered throughout as well as a white substance frozen to the floor in front of the food shelves A handbook titled "Culinary Processes and Procedures," dated 12/2016, read in part, "Reference all state and local licensing and regulatory standards." On 08/25/25 at 11:34 a.m., the dietary manager was asked what was the policy for cleaning the kitchen equipment and floors. They stated, "At	C 391		

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 08/28/2025
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C 391	Continued From page 3 least once per week. The old kitchen crew left a few weeks ago and it has not been cleaned since." The dietary manager was shown the unlabeled and undated food in the refrigerator and dry storage. They were asked what the policy was for labeling and dating food. The dietary manager stated, "Everything should be labeled and dated." The dietary manager was shown the two boxes of Quick Oats, Liquid Whole Egg, and the open gallon of milk. They were asked how foods were to be stored. They stated everything must be covered. The dietary manager stated the ice machine was cleaned monthly and it had not yet occurred for the month of August. They were asked if cleaning the ice machine monthly was sufficient, given the condition of the ice machine. The dietary manager stated, "I've never seen on like this and since I'm not here all the time I'm not sure." On 08/25/25 at 12:39 p.m., the dietary manager was asked to show the cleaning schedule for the kitchen. They stated, "It hasn't been followed, so I don't have one."	C 391		
C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status;	C 532		

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 08/28/2025
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C 532	Continued From page 4 (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure resident assessments accurately reflected the resident status for 1 (#3) of 10 sampled residents reviewed for assessment accuracy. The administrator identified 88 residents resided in the center. Findings: On 08/25/25 at 12:26 p.m., Resident #3 was observed ambulating with a walker from the elevator to their apartment. On 08/25/25 at 12:55 p.m., Resident #3 was observed getting up from their couch independently and walking to the restroom. A "Comprehensive Annual Assessment," dated 03/05/25, showed Resident #3 was admitted to the center on 02/08/23 with diagnoses to include osteoporosis, hypertension, and mild cognitive impairment. The assessment showed Resident #3 required routine hands on assistance with transfers and/or changes in position.	C 532		

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 08/28/2025
NAME OF PROVIDER OR SUPPLIER THE HARRISON OF OKLAHOMA CITY AL AND MC		STREET ADDRESS, CITY, STATE, ZIP CODE 10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170		
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C 532	Continued From page 5 On 08/25/25 at 1:16 p.m., CNA #1 was asked what assistance from staff Resident #3 required. They stated, "Reminders to come to meals and get dressed, but sometimes [they're] already dressed when we go in there. We help her shower, too." CNA #1 was asked if Resident #3 required assistance for transfers. They stated, "No." On 08/25/25 at 1:23 p.m., CNA #3 was asked what assistance from staff Resident #3 required. They stated, "Not a lot. Just showers and dressing, but [they] dress [themselves] half the time." CNA #3 stated Resident #3 was independently mobile with a walker. On 08/27/25 at 9:55 a.m., RN #1 was asked who was responsible for the resident assessments. They stated, "The licensed nurse in the building and I review and sign." RN #1 was asked to review Resident #3's most recent comprehensive assessment, dated 03/05/25. RN #1 was asked what Resident #3's assessment was for transferring ability. They stated, "[They] require assistance of staff to transfer." RN #1 was asked if the level of assistance for transferring was a 1 person or total assist with a gait belt. They stated it could be either. RN #1 was asked if Resident #3 ambulated independently with a walker, would they require assistance of staff to transfer. They stated, "Not usually." RN #1 was asked if based on staff statements and surveyor observation that Resident #3 did not require assistance with transfers, was the comprehensive assessment correct. They stated, "It is not correct, no."	C 532		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT	C 543		

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NAME OF PROVIDER OR SUPPLIER THE HARRISON OF OKLAHOMA CITY AL AND MC		STREET ADDRESS, CITY, STATE, ZIP CODE 10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170		
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C 543	Continued From page 6 (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 include a personal interview between the resident and/or the resident's representative for 3 (#1, 2, and #3) of 3 sampled residents reviewed for comprehensive assessments. The administrator identified 88 residents resided in the center. Findings: 1. Resident #2's "Annual Comprehensive Assessment," dated 10/17/24, showed Resident #2 was admitted to the center on 02/09/22 with diagnoses to include broken internal left hip prosthesis and hypothyroidism. 2. Resident #3's "Comprehensive Annual Assessment," dated 03/05/25, showed Resident #3 was admitted to the center on 02/08/23 with diagnoses to include osteoporosis, hypertension, and mild cognitive impairment. 3. Resident #1's "Oklahoma Memory Care" assessment, dated 07/23/25, showed diagnoses	C 543		

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C 543	Continued From page 7 which included coronary artery disease, chronic kidney disease, and major neurocognitive disorder. Reviews of these assessments for Residents #1, 2, and #3, showed no personal interview signatures to indicate a personal interview was conducted. On 08/27/25 at 12:59 p.m., RN #1 was asked for resident assessments with the resident and/or the resident's representative signatures. They stated, "Everything we have is what I gave you." RN #1 was asked if residents and/or the resident's representative signatures would indicate they were involved in the assessment. They stated, "Yes." RN #1 was asked if the assessments for Residents #1, 2, and #3 were signed by the residents and or/resident's representative. They stated, "No."	C 543			
C 552	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 center failed to ensure a comprehensive care plan (individualized service plan) was created for 1 (#8) of 10 sampled residents reviewed for care	C 552			

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C 552	Continued From page 8 plans. The administrator identified 88 residents resided at the center. Findings: An undated policy titled "Individualized Service Plan," read in part, "An overall interdisciplinary Individual Service Plan (ISP) is generated from the Comprehensive Assessment/Resident Health and Service Evaluation in [emr] for each resident who moves into the Community. The ISP describes the care and services that is to be given. The Plan assures that each resident receives assistance that is individualized to everyday living needs that promote health and well-being and guides Associates in their daily tasks." Resident #8's "Oklahoma Memory Care" assessment, dated 07/23/25, showed diagnoses which included Alzheimer's, dementia, and cardiac arrhythmia. The assessment showed Resident #8 had long and short term memory impairment and a history of wandering. There was no care plan located in Resident #8's hard chart at the nurses station or in the electronic medical record. On 08/27/25 at 12:17 p.m., the resident care director stated they were not sure who was responsible for completing the care plans. They stated they do the assessments and there was not a place on there for care plans. They stated the care plans were all digital and in the electronic medical record system. On 08/27/25 at 12:31 p.m., the resident care	C 552		

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C 552	Continued From page 9 director stated there was a care plan dated 08/27/25, but when the document was opened, it was blank. The resident care director was unable to state a care plan was completed per regulation. On 08/27/25 at 12:43 p.m., the regional RN stated the care plans were the responsibility of the resident care director and the regional RN for now, and they were stored in the electronic medical record. On 08/27/25 at 12:45 p.m., the regional RN stated they did not locate a care plan for Resident #8. They stated there absolutely should have been one.	C 552			
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure direct care staff had CPR training for 1 (CNA #4) of 5 sampled employees whose record was reviewed for CPR training. The administrator identified 88 residents resided in the center.	C 954			

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C 954	Continued From page 10 Findings: A review of CNA #4's employee file showed no documentation of CPR training. On 08/27/25 at 2:25 p.m., RN #1 was asked for CNA #4's CPR training documentation. On 08/28/25 at 8:45 a.m., RN #1 was again asked for CNA #4's CPR training documentation. They stated, "[They] have them assigned, but [they] have not completed it." RN #1 was asked if the center's policy states the CPR training was to completed upon hire. RN #1 stated, "Yes, it is." The center's employee training policy was requested. On 08/28/25 at 9:10 a.m., RN #1 stated, "We do not have a policy for CPR training."	C 954		
C1110 SS=F	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes.	C1110		

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C1110	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a quality assurance committee met on a quarterly basis. The administrator identified 88 residents resided in the center. Findings: On 08/27/25 at 12:59 p.m., RN #1 was asked for the center's QA agenda for the past 12 months. On 08/27/25 at 1:43 p.m., RN #1 was again asked for the center's QA agenda for the past 12 months. RN #1 stated, "I cannot locate it, just bear with me." On 08/27/25 at 4:30 p.m., RN #1 stated, "I do not have the QA meetings."	C1110		
C1304 SS=D	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract.	C1304		

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C1304	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a responsible party was informed of care cost increases for 1 (#3) of 3 sampled residents reviewed for care cost increases. The administrator identified 88 residents resided in the center. Findings: A "Residency Agreement," dated 12/27/24, read in part, "Following any resident assessment, the community will notify the resident and responsible party of the results of the assessment and whether the resident's required level of care has changed. The resident or responsible party shall execute a Level of Care Change Form acknowledging the change and reflecting the new Level of Care Fee." A "Billing Statement," dated 03/01/25, showed Resident #3 was charged a total of \$8,079.00 for "Assisted Living" services rendered from 03/01/25 through 03/31/25. A "Salon Services Charge," was included in this statement for the amount of \$213.00. A "Comprehensive Annual Assessment," dated 03/05/25, showed Resident #3 was admitted to	C1304		

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C1304	Continued From page 13 the center on 02/08/23 with diagnoses to include osteoporosis, hypertension, and mild cognitive impairment. A "Billing Statement," dated 04/01/25, showed Resident #3 was charged \$11,575.66. Resident #3 was charged \$7,254.00 for "Assisted Living" services rendered from 04/01/25 through 04/30/25. They were charged \$1,952.66 for "AL Resident Plus 3" services rendered from 03/05/25 through 03/31/25 and \$2,200.00 for "AL Resident Plus 3" services rendered from 04/01/25 through 04/30/25. A "Salon Services Charge," was included in this statement for the amount of \$170.00. On 08/25/25 at 12:32 p.m., Resident #3's family member stated, "In February or March we got a new bill that had been raised by \$1600 per month. We were not notified about it and didn't sign anything. When I asked about the bill I was told [their] level of care increased." The family member was asked if they were told why Resident #3's level of care increased. They stated, "No. They couldn't say." On 08/27/25 at 9:55 a.m., RN #1 was asked who was responsible for the resident assessments. They stated, "The licensed nurse in the building and I review and sign." RN #1 was asked to review Resident #3's most recent comprehensive assessment, dated 03/05/25. RN #1 was asked what Resident #3's assessment was for transferring ability. They stated, "[They] require assistance of staff to transfer." RN #1 was asked if the level of assistance for transferring was a 1 person or total assist with a gait belt. They stated it could be either. RN #1 was asked if Resident #3 ambulated independently with a walker, would they require assistance of staff to transfer. They	C1304		

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C1304	Continued From page 14 stated, "Not usually." RN #1 was asked if based on staff statements and surveyor observation Resident #3 did not require assistance with transfers was the comprehensive assessment correct. They stated, "It is not correct, no." RN #1 was asked what assistance from staff would increase the cost of care. They stated, "Multiple things, whether they need bathing that they didn't require before, or medications." RN #1 was asked if requiring assistance from staff for transfers would increase Resident #3's level of care and in turn increase the monthly cost of care. They stated, "Yes." RN #1 could not specifically identify why Resident #3's level of care would have been increased.	C1304		
C1505	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 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	C1505		

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C1505	Continued From page 15 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 notify a resident's responsible party/emergency contact of a change in condition for 2 (#1 and #8) of 3 sampled residents reviewed for change in condition. The administrator identified 88 residents resided in the facility. Findings: A policy titled " Change of Condition," dated 09/09/20, read in part, "A change of condition will be evaluated and documented for residents who exhibit significant deviation, from[sic] their baseline, in physical or mental status such as -Change in medical condition (e.g. multiple falls, skin issues, food intake changes, etc.)" 1. Resident #1's "Oklahoma Memory Care" assessment, dated 07/23/25, showed diagnoses	C1505		

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C1505	Continued From page 16 which included coronary artery disease, chronic kidney disease, and major neurocognitive disorder. The assessment showed Resident #1 had short term memory impairment and had poor judgment. Review of Resident #1's incident reports, dated 06/03/25 through 8/27/25, showed a total of 10 incident reports. Of the 10 incident reports completed, three did not have documentation of family notification within the 24 hours of the incident. a. 06/03/25, No family family, responsible party, or emergency contact notification found. b. 07/30/25, No family family, responsible party, or emergency contact notification found. c. 08/23/25, No family family, responsible party, or emergency contact notification found. On 08/27/25 at 12:04 p.m., the resident care director stated the process for notifying family of incidents was that if the resident care director was in the building they would get notified from the staff and then go to the incident to see the resident, the medication aide would start the incident report and contact the family or we work together in the process and it would all be documented in the electronic medical record. On 08/27/25 at 12:05 p.m., the resident care director reviewed Resident #1's incident reports listed in the electronic medical record starting on 06/03/25. They stated there was no notification to the residents family, responsible party, or emergency contact for the incidents on 06/03/25, 07/30/25, and 08/23/25. 2. Resident #8's "Oklahoma Memory Care" assessment, dated 07/23/25, showed diagnoses	C1505		

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C1505	Continued From page 17 which included Alzheimer's, dementia and cardiac arrhythmia. The assessment showed Resident #8 had long and short term memory impairment and a history of wandering. Review of Resident #8's incident reports from June 2025 to August 2025, dated 08/19/25, showed an incident report with no family, responsible party, or emergency contact notification found. On 08/27/25 at 12:17 p.m., the resident care director reviewed Resident #8's incident report dated 08/19/25. They stated there was no notification to the residents family, responsible party, or emergency contact for the incident on 08/19/25.	C1505		
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 Statutes, 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,	C1512		

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C1512	Continued From page 18 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; 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;	C1512		

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C1512	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a resident was free from neglect for 1 (#2) of 3 sampled residents reviewed for falls. The administrator identified 88 residents resided in the center. Findings: A policy titled "Resident Incident Reports," dated 09/10/20, read in part, "A resident assessment, or evaluation, is completed after a resident incident/accident. Emergency services (911) is called immediately if needed or if there is an uncertainty of the resident's needs." An "Annual Comprehensive Assessment," dated 10/17/24, showed Resident #2 was admitted to the center on 02/09/22 with diagnoses to include broken internal left hip prosthesis and hypothyroidism. The assessment showed Resident #2 required stand by assistance for bathing, ambulated independently with a walker, and was at a moderate risk for falls. Resident #2's apartment camera footage, dated 02/14/25 at 12:54 a.m., was reviewed on 08/27/25. The footage showed Resident #2 was walking in their apartment with their walker from the bathroom back to their bed, fell backwards, rolled onto their right side, and began moaning. Resident #2 called, "Help!" several times throughout the next 1 hour and 55 minutes. Resident #2 was heard moaning in pain and stating, "Hurt, hurt." The footage showed at 1:52 a.m., Resident #2 yelled, "I can't get up, please help!" and pulled their blanket off of their bed on	C1512		

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 08/28/2025
NAME OF PROVIDER OR SUPPLIER THE HARRISON OF OKLAHOMA CITY AL AND MC		STREET ADDRESS, CITY, STATE, ZIP CODE 10801 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73170		
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C1512	Continued From page 20 top of them. Resident #2 continued moaning throughout their calls for help. At 2:13 a.m., Resident #2 was seen on the floor with their back to the camera and was moving their arms around. At 2:49 a.m., CNA #5 was seen entering Resident #2's apartment where the resident was breathing heavy, lying on the floor. CNA #5 was heard saying, "Why are you sleeping on the floor?" Resident #2 stated, "I'm hurting," and continued moaning. CNA #5 stated, "It's ok, its ok. Just hold on." CNA #5 was observed to have an object in their hand, bent down to Resident #2, and CNA #5's walkie announced, "Assistance no longer needed for [Resident #2's room number]." The footage showed at 2:50 a.m., CNA #5 again asked Resident #2, "Why are you sleeping on the floor?" CNA #5 attempted to remove the blanket from the resident and Resident #2 stated, "I'm cold." CNA #5 placed the blanket back on the resident and stated, "I will be right back." CNA #5 placed a pillow under Resident #2's head and left the apartment. At 2:53 a.m., CNA #5 and CMA #2 were observed entering Resident #2's apartment. CMA #5 asked Resident #2 several times why they were sleeping on the floor. Resident #2 was heard moaning in pain and stating, "I'm hurt." CMA #2 was heard asking Resident #2 if they fell and the resident did not respond. The resident was breathing heavily and moaning. Both CNA #5 and CMA #2 stood on either side of Resident #2 and assisted them to sit up on the floor. The staff members hooked their arms under Resident #2's arms. CNA #5 was observed grabbing the back of the resident's pants and both staff members attempted to stand Resident #2 up. Both staff members were seen struggling to help the resident stand as Resident #2 was unable to stand. Both staff members lifted the resident by the back of the pants with their arms still hooked under the residents' arms. Resident #2's legs	C1512		

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C1512	Continued From page 21 were observed dangling and both staff members carried them to their bed. As staff were setting Resident #2 on the bed they stated, "This hurts." Resident #2 was observed to be moaning throughout this process. Both staff members helped the resident lie down in their bed, covered them with a blanket, turned off the light, and left the apartment. Resident #2 was observed to be moaning and breathing heavily throughout the night. The footage showed at 5:11 a.m., Resident #2 began moaning and repeatedly yelling, "Please help!" At 5:13 a.m., CNA #5 and CMA #2 enter the resident's apartment and asked the resident what was wrong. Resident #2 stated, "My back is killing me." CMA #2 affirmed they heard the resident by asking, "Your back is killing you?" They then walk out of the room while CNA #5 began rubbing Resident #2's back. The resident continued moaning in pain. At 5:15 a.m., CNA #5 assisted Resident #2 to readjust in their bed and Resident #2 stated, "It hurts." At 5:18 a.m., CNA #5 stated, "I'll be right back." CNA #5 then left the apartment. The footage showed at 5:34 a.m., Resident #2 began moaning in pain and yelling, "Help! Please help!" At 5:35 a.m., CNA #5 entered Resident #2's apartment and was observed stating something unintelligible. Resident #2 was breathing heavy and moaning. At 5:37 CNA #5 exited the apartment. The footage showed at 5:56 a.m., staff entered the room with EMSA and a paramedic asked Resident #2 what was hurting. The resident responded by yelling in pain and breathing heavy, shallow breaths. Resident #2 finally responded to the paramedic by stating, "Everything." The paramedic asked the staff members if the cut on Resident #2's head was new or if it had been there. Neither staff responded and the paramedic stated, "It looks new, [they] still got blood in [their] hair." The footage showed at 6:04 a.m. the	C1512		

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C1512	Continued From page 22 paramedics placed Resident #2 on a stretcher with a cervical collar applied and transported the resident to the hospital. A "Neurosurgery Consult," dated 02/14/25, read in part, "[Resident #2] presented to the ED after a mechanical fall. [They] were found to have a thoracic fracture. [Resident #2] has a history of significant dementia. [Resident #2's family member] states [they] would not opt for any sort of surgical intervention and I think that this is very reasonable." A "Physician's Order," dated 02/14/25, read in part, "Hospice to evaluate and treat." A "History and Physical," dated 02/15/25, read in part, "[Resident #2] in residence in AL. [They] now live in an apartment by [themselves] with [spouse] passing four months ago. Since then there has been a clear decline. On 02/14/25, the patient had an unwitnessed fall in [their] room. The patient was treated for pain in the ER as [their] pain appeared significant. [They] were also anxious and tearful." On 08/26/25 at 9:46 a.m., CMA #3 was asked what the center's procedure was for a resident fall. They stated, "We go in, make sure they're ok. As a med aide, we take their vitals before assisting them to get up. If there's no injuries we help them get up, make sure they're safe. We notify family, nurse, and physician. If something looks off we call EMSA and we do our incident reports in the computer." On 08/26/25 at 9:51 a.m., CNA #3 was asked what the center's procedure was for a resident fall. They stated, "I'll call my med aide and they will come to assess and go from there. They take	C1512		

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C1512	Continued From page 23 the lead in a fall." On 08/26/25 at 9:52 a.m., CMA #1 was asked what the center's procedure was for a resident fall. They stated, "If staff lets me know a resident fell, I check the resident's vitals and find out what happened that caused the fall. I see if they can move their extremities and if not I let the nurse know and they'll tell me if I need to call EMSA or if they can be checked once the nurse gets here." On 08/27/25 at 1:40 pm., RN #1 was asked for documentation showing staff notified the nurse of Resident #2's fall on 02/14/25. They stated, "Staff typically call the on call nurse and then we get an email from the on call nurse. I don't have anything for [Resident #2's] fall." RN #1 was asked if staff should have called the nurse and family right when Resident #2 expressed pain after their fall. RN #1 stated, "Yes." On 08/27/25 at 2:55 p.m., Resident #2's family member was asked what they could recall about Resident #2's fall on 02/14/25. They stated, "[They] fell about 12:54 a.m. and laid there moaning in pain, calling for help. No one came until about 2:49 a.m. and staff put [Resident #2] in bed. Staff didn't call me until 5:13 a.m. and told me [they] were in pain and did I want to send [them] to the ER. I reviewed the video and told them to call EMSA because [they] could be seriously hurt. They let [them] lay there for hours in pain." Resident #2's family member stated they suffered from a thoracic back fracture and opted for no surgical intervention given the risks. On 08/28/25 at 8:11 a.m., CNA #5 was asked what they could recall about Resident #2's fall on 02/14/25. They stated, "There was a call light and we were attending to another resident. Then I	C1512		

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C1512	Continued From page 24 went into [Resident #2's] room and [they] were on the floor. I couldn't help [them] up myself, so I had to call my coworker." CNA #5 was then asked if Resident #2 complained of pain. They stated, "No." CNA #5 was asked if Resident #2 said anything at all. CNA #5 stated, "[They] didn't say anything because we asked [them] how did [they] get to the floor and what happened. All [they] kept saying is, 'I'm cold.'" CNA #5 was asked if Resident #2 could normally stand up on their own. They stated, "Yes, because I think [they] had a walker." CNA #5 was asked if Resident #2 was able to stand on their own when the staff members assisted them. They stated, "No. We just helped [them] to the bed. We each were on one side and lifted [them] to the bed." CNA #5 denied Resident #2 was moaning or stated they hurt. CNA #5 was told the video footage had been reviewed and it did show Resident #2 was moaning and stated they were hurt. CNA #5 stated, "No." On 08/28/25 at 8:41 a.m., CMA #2 was asked what they could recall about Resident #2's fall on 02/14/25. They stated, "One resident called and wanted to be changed, so my coworker and I went in there and then as soon as we get in the room we had another light come on which was [Resident #2]. I told my coworker to go check what [they] wanted and before I know it [they're] running, coming back saying [Resident #2] was on the floor. [CNA #5] helped me pick up [Resident #2] and put [them] in bed." CMA #2 was asked what their action was when Resident #2 said they were in pain and hurting. They stated, "I asked if [they] were in pain at that time and [they] did not say [they] were in pain. When I went to check on [them] again [they] were screaming in pain. I called the family and they said to send [them] to the hospital." CMA #2 was asked if they	C1512		

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C1512	Continued From page 25 contacted the center's nurse when Resident #2 fell. They stated, "I communicated it to [them] in the morning." CMA #2 could not remember the nurse they spoke with.	C1512		
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were educated on abuse within 90 days of hire for 1 (CNA #4) of 5 sampled employees whose records were reviewed for abuse training. The administrator identified 88 residents resided in the center. Findings: A review of CNA #4's employee record showed they were hired at the center on 09/12/24. Their employee record did not show they were educated on abuse within 90 days of hire, which would have been by 12/11/24. On 08/27/25 at 2:25 p.m., RN #1 was asked for	C1972		