Oklahoma State Department of Health
Creating a State of Health

December 10, 2019

License Number: AL5599

Ms. Alixandria Ruoff, Administrator
Heritage Point Of Oklahoma City
12000 North Macarthur Blvd
Oklahoma City, OK 73162

RE: Survey Event ID: M2WJ11

Dear Ms. Ruoff:

On **November 26, 2019**, 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 November 26, 2019.

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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. 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) 271-6868 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 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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 or conducted in a face-to-face 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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.

Sincerely,

Lisa Calderin

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL5599	A BUILDING _____ B WING _____	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE POINT OF OKLAHOMA CITY	12000 NORTH MACARTHUR BLVD OKLAHOMA CITY, OK 73162

(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 re-licensure survey was conducted on 11/25/19 and 11/26/19. Current census was 41. Deficient practices were cited as follows.	C 000		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure hot water temperatures did not exceed 115°F (degrees Fahrenheit) for 3 (#1, 4, and #6) of 6 sampled residents who had access to hot water in their bathrooms. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1's water temperature was measured at 117.6°F, resident #4's water temperature was measured at 120°F, and resident #6's water temperature was measured at 120.3°F at the bathroom faucet. On 11/25/19 at 2:56 p.m., the maintenance director stated he thought the hot water temperatures could not be over 120°F. He stated	C 701		

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	AL5599	A. BUILDING _____ B WING _____	11/26/2019

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C 701	Continued From page 1 he checked the hot water temperatures in random apartments weekly. The weekly hot water temperature monitoring logs were not provided by the maintenance director.	C 701		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure the medications were reviewed monthly by a registered nurse for 7 (#1 through #3 and #5 through #8) of 8 sampled residents who were administered physician ordered medications. This failed practice had the potential for more than minimal harm at a pattern. Findings: The records for residents #1 through #3 and #5 through #8 were reviewed and did not document the registered nurse had done monthly medication reviews. On 11/26/19 at 3:46 p.m., the licensed practical nurse (LPN) #1 stated the monthly medication reviews for resident #2 and #5 had not been done by the registered nurse every month. At 4:51 p.m., LPN #2 stated the registered nurse did not do all the monthly medication reviews. She stated the LPN who was no longer employed at the center had signed some of the monthly medication reviews for resident #1, 6 and #8.	C 921		

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	AL5599	A. BUILDING: _____ B. WING _____	11/26/2019

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C 921	Continued From page 2 At 5:26 p.m., LPN #1 stated the monthly medication reviews were not done by the registered nurse every month for resident #3 and #7.	C 921		
C1505 SS=E	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 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 observation, interview and record review it was determined the center failed to ensure:	C1505		

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C1505	Continued From page 3 a) Medications were available for administration for 4 (#2, 5, 6, and #8,) of 10 sampled residents who had their medications ordered and administered by the center's employees and; b) Medications were administered as ordered by the physician for 1 (#10) of 2 sampled residents who were administered injections by the center's nurse. These failed practices had the potential for more than minimal harm at a pattern. Findings: a) Medications available RESIDENT #2 Resident #2 had an order for melatonin at bedtime for insomnia, macrobid daily for infection prevention, and aspercreame every morning at 6:30 a.m., and every 4 hours as needed for muscle pain. The medication administration record (MAR), dated 11/2019, documented the melatonin was not administered on 11/01/19, the macrobid was not administered on 11/15/19 and 11/22/19, and the aspercreame was not administered on 11/01/19, 11/04/19 through 11/06/19 because the medications were on order. RESIDENT #5 Resident #5 had an order for risperidone twice a day at 8:00 a.m. and 7:00 p.m., for behaviors with agitation. The MAR, dated 11/2019 documented the risperidone was not administered at 8:00 a.m., and the 7:00 p.m., dose was not administered until 9:55 p.m., because the medication was on order and arrived late.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 4 RESIDENT #6 Resident #6 had an order for Alphagan eye drops to be administered twice a day for glaucoma. The MAR, dated 11/2019, documented the alphagan had not been administered on 11/22/19, 11/23/19, 11/24/19 and 11/26/19 because of "other problems." RESIDENT #8 Resident #8 had an order for levothyroxine to be administered every morning. The MAR, dated 11/2019, documented the levothyroxine had not been administered on 11/11/19 through 11/14/19 because the medication was"on order", "on the way", and "not seen." On 11/26/19 at 3:46 p.m., the licensed practical nurse (LPN)#1 stated the medication refills were ordered 7 days in advance. She stated the residents should never run out of their medications. LPN #1 stated resident #5 should not have missed a dose of his risperidone and resident #6 should have his eye drops. She stated resident #8's levothyroxine was a pharmacy issue. At 4:42 p.m., LPN #2 with certified medication aide (CMA) #6 looked for resident #6's alphagan eye drops in the medication cart. The resident's eye drops were not in the medication cart or in the medication room. The CMA stated she used the "last little bit" of the eye drops on 11/23/19. She stated the medication should have been reordered. An in-service, dated 10/29/19, documented, "...Mandatory to report to DON/Nurse...Anytime a medication has run out or is unavailable..." (This	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5599	A BUILDING _____ B WING _____	11/26/2019

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C1505	Continued From page 5 statement was in bold capital letters.) b) Medications administered RESIDENT #10 Resident #10 had diagnosis which included vitamin B deficiency and had an order for Cyanocobalamin (vitamin B12) intramuscular injection every month on the 15th. The MAR, dated 11/2019, documented the vitamin B12 was not administered on 11/11/19 because a nurse needed to administer the injection on 11/15/19. No documentation was located in the record to indicate the B12 was administered on 11/15/19. On 11/26/19 at 3:46 p.m., LPN #1 stated she had not administered the B12 injection to resident #10 At 4:58 p.m., LPN #2 stated she did not administer the B12 injection to resident #10 on 11/15/19.	C1505		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5599	HERITAGE POINT OF OKLAHOMA CITY

Type of Survey (select all that apply)

2								

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A								

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
BS 36191	11/25/2019	11/26/2019	1.00	0.00	15.75	0.00	4.75	6.00
AD 35195	11/25/2019	11/26/2019	0.00	0.00	13.00	0.00	4.25	1.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

DEC 11 2019

Oklahoma State Department of Health
Creating a State of Health

December 23, 2019

License Number: AL5599

Ms. Alixandria Ruoff, Administrator
Heritage Point Of Oklahoma City
12000 North Macarthur Blvd
Oklahoma City, OK 73162

RE: Survey Event M2WJ11

Dear Ms. Ruoff:

On November 26, 2019, 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 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 **January 31, 2020**.

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) 271-6868.

Sincerely,

Katie Stagner

for Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/19/2019** **Facility Name:** Heritage Point of Oklahoma City **License Number:** AL5599 **Survey Event ID:** M2WJ11 **Date Survey Completed: 11/26/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C701 SS=E	Based on: observation and interview it was determined the center failed to ensure hot water temperatures did not exceed 115 degrees Farenheit for 3(#1, #4, and #6) of 6 sampled residents who had access to hot water in their bathrooms.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state and/or federal law.

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?	The center immediately adjusted the water temperature down to an acceptable level. The center will ensure compliance with the regulation and the center's policy through regular oversight and monitoring of water temperatures by the Maintenance Director and/or executive director (or appropriate designee). Maintenance Director was in-serviced about the water temperature regulation.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The center will ensure compliance with the regulation and the center's policy through regular oversight and monitoring of water temperatures by the Maintenance Director and/or executive director (or appropriate designee). Maintenance Director was in-serviced about the water temperature regulation.
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?	Weekly, the Maintenance Director will take random samples of water temperatures in a variety of places throughout each home to ensure compliance with the regulation. Immediate adjustments will be made as needed to keep water temperatures within regulation.
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.	a. The Executive Director and/or designee will monitor and periodically review the temperature logs as well as periodically checking water temps throughtout all 3 homes to ensure compliance with the regulation. b. Water temperature logs will be reviewed for compliance by the QA team at each meeting and all determined needs communicated to the maintenance director and executive director.

	c. Documentation of water temperature samples will be maintained in a specific binder under the direction of the maintenance director.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/31/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **AlixAndria Ruoff** OAC 310:663-25-4(F)	**Date 12/19/2019**

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: 12/19/2019** **Facility Name:** Heritage Point of Oklahoma City **License Number:** AL5599 **Survey Event ID:** M2WJ11 **Date Survey Completed: 11/26/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921 SS=E	Based on: observation and interview it was determined the center failed to ensure the medications were reviewed monthly by a registered nurse for 7 (#1 through #3 and #5 through #8) of sampled residents who were administered physician ordered medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state and/or federal law.

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?	The Wellness Director or designee will audit all resident POS's for ensure compliance with the regulation and the center's policy. RN will sign off on any not signed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Wellness Director will ensure compliance with the regulation and the center's policy through regular oversight and monitoring of RN review and signature of all POS's.
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?	Monthly, the Wellness Director or designee will review POS's to ensure compliance with the regulation. Wellness Director will audit the previous month's POS's by the 5th of the following month to ensure compliance with the regulation.
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.	a. Wellness Director will audit the previous month's POS's by the 5th of the following month to ensure compliance with the regulation. b. RN signature on POS's will be reviewed for compliance by the QA team at each meeting and all determined needs communicated to the wellness director and executive director. c. Signed POS's will be kept in each resident's record fo review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/31/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **AlixAndria Ruoff** x	**Date 12/19/2019**

OAC 310:663-25-4(F)

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: 12/19/2019** **Facility Name:** Heritage Point of Oklahoma City **License Number:** AL5599 **Survey Event ID:** M2WJ11 **Date Survey Completed: 11/26/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505 SS=E	Based on: observation and interview it was determined the center failed to ensure: a) Medications were available for administration for 4 (#2, 5, 6, and 8) of 10 sampled residents who had their medications ordered and administered by the center's employees and; b) Medications were not administered as ordered by the physician for 1 (#10) of 2 sampled residents who were administered injections by the center's nurse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state and/or federal law.

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?	The Wellness Director or nurse designee will audit all resident MAR's for compliance with the regulation. CMA's, ACMA's, and MAT's will be trained through in-service on their requirement to immediately report any medications that are running low, have run out, and/or were not given to a resident to the Wellness Director or Charge Nurse.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The Wellness Director or nurse designee will audit all resident MAR's for compliance with the regulation. CMA's, ACMA's, and MAT's will be trained through in-service on their requirement to immediately report any medications that are running low, have run out, and/or were not given to a resident to the Wellness Director or Charge Nurse. In addition, the Wellness Director or nurse designee will conduct periodic MAR audits for compliance with the regulation.
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?	The Wellness Director or nurse designee will audit all resident MAR's for compliance with the regulation. CMA's, ACMA's, and MAT's will be trained through in-service on their requirement to immediately report any medications that are running low, have run out, and/or were not given to a resident to the Wellness director or Charge Nurse. In addition, the Wellness Director or nurse designee will conduct periodic MAR audits for compliance with the regulation. Also, the Executive Director will review/audit the MAR's monthly for compliance. Also, all medications will be put on auto-refill through the pharmacy when available.

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.	a. Wellness Director and Executive Director will periodically review MAR's for compliance and indications of improvement. b. Compliance with medication administration will be reviewed for compliance by the QA team at each meeting and all determined needs communicated to the wellness director and executive director. c. MAR's will be kept in each resident's record fo review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/31/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature AlixAndria Ruoff OAC 310:663-25-4(F)	**Date 12/19/2019**

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

February 12, 2020

License Number: AL5599

Ms. Alixandria Ruoff, Administrator
Heritage Point Of Oklahoma City
12000 North Macarthur Blvd
Oklahoma City, OK 73162

RE: Survey Event M2WJ12

Dear Ms. Ruoff:

On **February 4, 2020,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 26, 2019,** have now been corrected effective **January 31,2020.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Kaue Stagner

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

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
	AL5599	A. BUILDING _____ B. WING _____	R 02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE POINT OF OKLAHOMA CITY	12000 NORTH MACARTHUR BLVD OKLAHOMA CITY, OK 73162

(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 follow-up survey was conducted on 02/04/20. Current census was 40. All deficient practice was cleared.	{C 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5599	HERITAGE POINT OF OKLAHOMA CITY

Type of Survey (select all that apply)

2	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 36191	02/04/2020	02/04/2020	0.75	0.00	2.00	0.00	1.75	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**