Oklahoma State Department of Health
Creating a State of Health

December 13, 2019

License Number: AL7001

Mr. Dan Stiles, Administrator
Heritage Community
1401 N Lelia
Guymon, OK 73942

Survey Event ID: E67D11

Dear Mr. Stiles:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **November 19, 2019.** No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: Heritage Community
Address: 1401 N Lelia
City, State, Zip: Guymon, OK 73942
Provider #: AL7001
Complaint #: OK00054259
Investigation Date(s): 11/18/19 through 11/19/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure documentation was accurate.	US
2. The center failed to provide an abuse free environment.	US

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 11/18/19 at 2:30 p.m.

A sample of three residents, including the resident named in the allegation, was selected based on issues relevant to the allegations(s). The following regulatory area was investigated: accurate documentation and an abuse free environment.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: The regulation, referenced by the allegation, was unsubstantiated. See the following details related to the investigation.

Resident records were reviewed including documentation for a resident that left the center unaccompanied by staff. An incident report documented the resident was missing, found outside the center by staff and was only oriented to self. The fax cover sheet documented "elopement". Three staff, including the staff member that found the resident outside the facility, were interviewed. The staff all stated the resident was found outside the facility without the knowledge of anyone on staff and the resident was confused and disoriented. This documentation was found to be accurate as this incident met the definition of "elopement".

Allegation #2: The regulation, referenced by the allegation, was unsubstantiated. See the following details related to the investigation.

Three resident records were reviewed. One resident's records included a physician's order, dated 09/05/19, for the center to "stop monitoring the resident after 10:00 p.m." The resident stated no one woke him up or bothered him at night. The staff was interviewed and they all stated they cracked the door open to look in the resident's room just to make sure he was safe, but they did not awaken him. The nurse was asked what the physician meant by "monitoring" and she stated she would call and clarify with the physician. She came back and said the physician said "monitoring" meant taking the resident's vital signs and waking him up. Since the staff was neither waking the resident nor taking his vital signs, they were not "monitoring" him.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Teena Cornett CHFS IV

Teena Cornett, RN CHFS IV

Date report completed: 11/25/2019

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
	AL7001	A. BUILDING: _____ B WING _____	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COMMUNITY	1401 N LELIA GUYMON, OK 73942

(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 An abbreviated survey was conducted to investigate complaint #OK00054259. Resident census was 34. No deficient practice was cited.	C 000		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7001	HERITAGE COMMUNITY

Type of Survey (select all that apply)

3				

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 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. 36967	11/18/2019	11/19/2019	0.25	0.00	4.50	0.00	4.50	2.00
2. 41872	11/18/2019	11/19/2019	0.25	0.00	4.50	0.00	4.25	0.00
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 16 2019