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**Delivery via email to: [jolynn.hodges@guymonheritagecommunity.com](mailto:jolynn.hodges@guymonheritagecommunity.com)**

April 7, 2023

License Number: AL7001

Ms. JoLynn Hodges, Director of Nursing  
Heritage Community  
1401 N Lelia  
Guymon, OK 73942

**RE: Survey Event ID: HGYT11**

Dear Ms. Hodges:

On **March 14, 2023**, 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 March 14, 2023.

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) 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 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  
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](mailto: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 [LTCEnforcement@health.ok.gov](mailto: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.

Sincerely,



Lisa Calvin, Enforcement Analyst  
Long Term Care  
Protective Health Services

Enclosure



Oklahoma State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL7001</b>        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/14/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HERITAGE COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1401 N LELIA<br/>GUYMON, OK 73942</b> |                                                                                                                          |                                                        |
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| C 000                                                         | <p>INITIAL COMMENTS</p> <p>A relicensure survey was conducted on 03/08/23 through 03/10/23, 03/13/23 and 03/14/23.</p> <p>The following abbreviations will be used in the writing of this report.</p> <p>ADL - Activities of Daily Living<br/>ADON - Assistant Director of Nursing<br/>AL - Assisted Living<br/>BFKST - breakfast<br/>BOM - Business Office Manager<br/>BM - bowel movement<br/>CNA - Certified Nursing Assistant<br/>DON - Director of Nursing<br/>GERD - Gastroesophageal Reflux Disease<br/>HOH - hard of hearing<br/>HR - Human Resources<br/>LTC - long term care<br/>LPN - Licensed Practical Nurse<br/>MAR - Medication Administration Record<br/>MCG/mcg - Microgram<br/>MG - Milligram<br/>ML - Milliliter<br/>Neuro - Neurological<br/>ppm - part per million<br/>sm - small<br/>SS - Social Services<br/>TAR - Treatment Administration Record<br/>UTI - Urinary Tract Infection</p> | C 000                                                                             |                                                                                                                          |                                                        |
| C 301<br>SS=D                                                 | <p>310:663-3-1(a) SERVICE IN ASSISTED LIVING</p> <p>(a) An assisted living center shall not care for any resident needing care in excess of the level that the assisted living center is licensed to provide or capable of providing.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | C 301                                                                             |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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

TITLE

(X6) DATE



Oklahoma State Department of Health

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| C 301                                                         | <p>Continued From page 1</p> <p>This Rule is not met as evidenced by:<br/>Based on record review, observation, and interview it was determined the center failed to ensure a resident did not exceed the level of care that the assisted living center was able and/or licensed to provide.</p> <p>The BOM identified 27 residents resided in the center.</p> <p>Findings:</p> <p>1. Resident #4 had diagnoses which included, dementia, psychotic mood disturbance, and anxiety.</p> <p>Resident #4's "Assisted Living Resident Service Contract," dated 12/02/2013, read in parts,"...Discharge Criteria...A resident is not eligible for residency in or continued residency in [Name of Facility] if one or more of the following circumstances is or becomes present...The resident poses a threat to self or others...The resident is unable to manage his or her activities of daily living independently or with the assistance available, including no more than a one-person assist...The resident experiences uncontrolled incontinence..."</p> <p>An undated, "Annual Assessment," documented Resident #4 was alert but forgetful, confused at times, and needed assistance of one staff for bathing and dressing. A slash mark was documented on toileting, transferring and ambulation. Resident #4 had occasional</p> | C 301                                                                             |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C 301                                                         | <p>Continued From page 2</p> <p>incontinence of bowel and bladder at times.<br/>Signed and dated by LPN #2 on 05/19/22.</p> <p>A "Behavior Note," dated 01/22/2023 at 5:18 a.m.,<br/>read in part, "...CNA notified this nurse that [they]<br/>smelled burning in this residents room. Resident<br/>had placed a news paper in [their] microwave in<br/>an attempt to cook it...Microwave was removed..."</p> <p>A "Nursing Note," dated 02/07/23, resident is<br/>having lot more confusion wandering off towards<br/>the memory care door looking for [their] room this<br/>am resident came to this writers door stating that<br/>[they] had not had anything to eat for days<br/>attempted to tell res [they] had just finished<br/>BKFST and [they] stated no..."</p> <p>A "Nursing Note," dated 02/09/23, read in parts,<br/>"...CNA reports that resident is opening multiple<br/>coffee pods in [their] room and adding just a little<br/>water to them and drinking it out of the pods..."</p> <p>A "Behavior Note," dated 02/24/23, read in parts,<br/>"...CNA reports resident uses the bathroom<br/>without assist and did not put clean brief on when<br/>done or remembered to clean self. Also reports<br/>resident hoarding utensils, food and snacks in<br/>room and will eat any leftover food that [the<br/>resident] takes to [their] room..."</p> <p>A "Behavior Note," dated 02/24/23, read in parts,<br/>"...CNA reports resident took coffee back to [the<br/>resident] room and emptied a coffee pod into<br/>[their] coffee and was drinking it with coffee<br/>grounds in it..."</p> <p>A "Nursing Note," dated 03/02/23, read in parts,<br/>"...CNA reports to this nurse that [they] went into<br/>residents room to check on [the resident] and [the<br/>resident] had bowel movement all other [sic] the</p> | C 301                                                                             |                                                                                                                          |                                                        |

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| C 301                                                         | <p>Continued From page 3</p> <p>bathroom floor and was wearing two briefs..."</p> <p>A "Nursing Note," dated 03/02/23, read in parts, "...CNA reports that resident is very incontinent of bowel and bladder..."</p> <p>A "Nursing Note," dated 03/10/23, read in parts, "...CNA reports to me that resident is hoarding coffee cups in [their] room. One cup that [CNA] found had coffee grounds in it and was growing mold..."</p> <p>On 03/09/23 at 7:20 a.m., Resident #4 was observed at the table eating breakfast. Resident #4 was spoken to but is HOH and did not respond.</p> <p>On 03/09/23 at 1:40 p.m., CNA #1 was asked what kind of assistance Resident #4 required for ADL's. They stated the resident required assistance of one staff for everything, except eating and the resident was totally incontinent. CNA #1 stated the resident has had a decline within the last year.</p> <p>On 03/09/23 at 3:25 p.m., Resident #4 was observed to attempt to stand from their wheelchair outside the memory care unit. Resident #4 was pushing the intercom button and pulling on the door. Resident #4 was asked if they were going to visit someone on the other side of the door. Resident #4 stated, "No, I am going out that door to leave this building and go back to my home where I use to live." The Resident was observed to attempt to open the door again. Staff was observed to redirect Resident #4.</p> <p>On 03/09/23 at 3:26 p.m., the ADON was shown Resident #4's annual assessment, dated 05/19/22, and asked what did the slash marks</p> | C 301                                                                             |                                                                                                                          |                                                        |



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| C 301                                                         | Continued From page 4<br><br>mean on toileting, transferring and ambulation.<br>The ADON was unsure. The ADON was asked if<br>Resident #4 had a decline in her ADL status and<br>should a significant change been done. The<br>ADON stated, "Yes."<br><br>A "Significant Change Assessment," dated<br>03/10/23, read in parts, "...Alert...Oriented x<br>2...Confused...resident wanders facility goes into<br>other rooms at times hoardes food and eating<br>utensils..." Resident's mobility, strength and gait<br>was poor and required assistance of one staff for<br>bathing, dressing, transferring, toileting and was<br>incontinent of bowel and bladder.<br><br>On 03/13/23 at 3:00 p.m., the DON was asked<br>when did they recognize Resident #4 had a<br>decline in their ADL's. The DON stated, "A couple<br>of months now." The DON stated, " [the resident]<br>ends up at memory care and is lost, [the resident]<br>was in here (tornado shelter with heavy metal<br>doors), we heard knocking on the door. [The<br>resident] couldn't get the door open."<br><br>On 03/14/23 at 8:40 a.m., on entry to Resident<br>#4's apartment with CNA #4, the resident was<br>observed sitting in their wheelchair in the<br>bathroom. Resident #4 requested assistance to<br>use the toilet. CNA #4 assisted the resident to<br>the toilet.<br><br>On 03/14/23 at 11:10 p.m., the DON was asked if<br>Resident #4 had met the discharge criteria. The<br>DON stated, "Yes." | C 301                                                                             |                                                                                                                          |                                                        |
| C 329<br>SS=F                                                 | 310:663-3-3(a)(9) DESCRIPTION OF SERVICES<br><br>(a) The assisted living center shall<br>describe the service to be provided or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | C 329                                                                             |                                                                                                                          |                                                        |

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| C 329                                                         | <p>Continued From page 5</p> <p>arranged in the assisted living center with respect to the following services:</p> <p>(9) provisions for evacuation of the building structure and staff to meet the evacuation needs of residents.</p> <p>This Rule is not met as evidenced by:<br/>Based on record review, and interview, the center failed to ensure the resident service contract contained provisions for evacuation of the building structure and staff to meet the evacuation needs of the residents for seven (#1, 2, 3, 4, 6, 7, and #8) of seven sampled residents contracts reviewed.</p> <p>An "Assisted Living Resident Condition and Care Overview," dated 03/08/23, documented 10 residents were unable to evacuate without assistance of staff.</p> <p>Findings:</p> <p>Resident #3, 4 and #6 resident service contracts did not contain provisions for evacuation of the building structure and staff to meet the evacuation needs of the residents.</p> <p>On 03/09/23 at 2:33 p.m., SS was asked if Resident #4's contract contained provisions for evacuation of the building structure and staff to meet the evacuation needs of the residents. SS</p> | C 329                                                                             |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C 329                                                         | <p>Continued From page 6</p> <p>reviewed the service agreement and stated, "No."</p> <p>On 03/09/23 at 2:44 p.m., SS was asked if Resident #6's contract contained provisions for evacuation of the building structure and staff to meet the evacuation needs of the residents. SS reviewed the service agreement and stated, "No."</p> <p>On 03/09/23 at 2:48 p.m., SS was asked if Resident #3's contract contained provisions for evacuation of the building structure and staff to meet the evacuation needs of the residents. SS reviewed the service agreement and stated, "No."</p> <p>2. Residents #1, 2, 7, and #8 resident service contracts did not contain provisions for evacuation of the building structure and staff to meet the evacuation needs of the residents.</p> <p>On 03/13/23 at 4:34 p.m., the DON was asked if Resident #8's service contract contained the provision for evacuation of the building structure. They stated, "No."</p> <p>On 03/14/23 at 9:40 a.m., the DON was asked if Resident #2's service contract contained the provision for evacuation of the building structure. They stated, "No, all the contracts are the same, if it isn't there, none of them have one."</p> <p>On 03/24/23 at 10:10 a.m., the DON was asked if Resident #1's service contract contained the provision for evacuation of the building structure. They stated, "No."</p> <p>On 3/24/23 at 11:30 a.m., the DON was asked if Resident #7's service contract contained the provision for evacuation of the building structure. They stated, "No."</p> | C 329                                                                             |                                                                                                                          |                                                        |

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| C 391                                                         | Continued From page 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | C 391                                                                             |                                                                                                                          |                                                        |
| C 391<br>SS=F                                                 | <p>310-663-3-8(a) FOOD STORAGE,<br/>PREPARATION AND SERVICE</p> <p>(a) Food shall be stored, prepared and served in<br/>accordance with Chapter 257 of this Title (relating<br/>to food service establishments) with the following<br/>additional requirements.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on record review, observation and<br/>interview, the facility failed to follow their policy to<br/>ensure the dish machine was in working order by<br/>testing and documenting dish machine<br/>temperatures and chemical results. This had the<br/>potential to affect 27 residents that resided in the<br/>facility.</p> <p>Findings:</p> <p>A "Dish Wash Machine Chemical &amp; Temperature<br/>Testing" policy, dated 06/01/08, read in parts,<br/>"...purpose of these tests is to assure proper<br/>sanitation is maintained...test and document the<br/>results of the water temperature and chemical<br/>concentration of the dish wash machine two<br/>times daily and to document the results on the<br/>appropriate record...maintain these records...for a<br/>minimum of one year (until after the next<br/>survey)..."</p> <p>Dietary Aide #1 provided a three-ring binder with<br/>documentation of dish machine monitoring. The<br/>binder contained monitor logs for January 2023.<br/>The Dish Machine Temperature log documented,<br/>twice a day, from 01/01/23 through 01/18/23 at 6<br/>a.m. The dish machine temperature log<br/>documented the temperatures to be 100 to 103.<br/>There was no documentation the water<br/>temperature or chemical concentration was</p> | C 391                                                                             |                                                                                                                          |                                                        |

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| C 391                                                         | <p>Continued From page 8</p> <p>monitored from 01/18/23 through 03/08/23.</p> <p>A binder, in the main kitchen area, contained no documentation of the water temperatures or chemical results from 02/28/23 through 03/08/23.</p> <p>On 03/08/23 at 11:47, an initial tour of the service kitchen was conducted. An unidentified dietary aide was observed to operate the dish machine. A tray of drinking utensils were ran through the dish machine and pulled aside to air dry. Dietary #1 was asked how staff ensured the dish machine was working properly. Dietary aide #1 stated the dish machine was a low temp with chemicals and the temperature should be around 120 and the testing strips should read at 100 ppm. Dietary aide #1 initiated the dish machine to run an empty cycle. During the cycle, Dietary aide #1 removed a test strip from a container that was labeled "Chlorine Test Paper," opened the door of the dish machine with and moistened the testing strip. The testing strip did not react. Dietary aide #1 repeated the process with the same results of no reaction to the chemicals. Dietary aide #1 was asked if there was a place the water temperatures and testing results were documented. Dietary aide #1 obtained a three ringed binder, and stated there was no documentation except for January 2023.</p> <p>On 03/08/23 at 12:05 p.m., in the main kitchen, Cook #1 was asked if there was documentation the dish machine had been monitored for water temperatures and chemical levels. The cook stated, "Yes," and provided a three ringed binder. The binder did not contain documentation of water temperature or chemical testing results from 02/28/23 through 03/08/23. The cook was asked if staff in the main kitchen were aware the dish machine on the AL unit was not in working</p> | C 391                                                                             |                                                                                                                          |                                                        |



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| C 391                                                         | Continued From page 9<br><br>order, and water temperatures and chemical results had not been documented since 01/18/23. The cook stated the dish machine on the AL unit had not worked for two or three weeks and AL staff were to bring the dirty dishes to the main kitchen to be washed. The cook stated, "We need to do some education."                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | C 391                                                                             |                                                                                                                          |                                                        |
| C 521<br>SS=D                                                 | 310:663-5-2(a) ASSESSMENT TIMEFRAMES<br><br>(a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review, and interview, the facility failed to complete an admission assessment within 30 days before or at the time of admission for one (#2) of nine sampled residents reviewed for an admission assessment.<br><br>Findings:<br><br>Resident #2 was admitted the the facility on 08/25/22, with diagnosis to include: altered mental status, dementia, delirium, peripheral vascular disease, history of falling, and a history of a traumatic fracture.<br><br>The clinical record contained no documentation an admission assessment had been completed. | C 521                                                                             |                                                                                                                          |                                                        |

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| C 521                                                         | Continued From page 10<br><br>On 03/14/23 at 9:40 a.m., the DON was asked to provide a admission assessment for Resident #2. They stated Resident #2 did not have an admission assessment during that time frame.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | C 521                                                                             |                                                                                                                          |                                                        |
| C 522<br>SS=D                                                 | 310:663-5-2(b) ASSESSMENT TIMEFRAMES<br><br>(b) The assisted living center shall complete the comprehensive assessment in accordance with the following:<br>(1) within fourteen (14) days after admission of the resident;<br>(2) once every twelve (12) months thereafter; and<br>(3) promptly after a significant change in the resident's condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and interview, the center failed to ensure significant change assessments were completed for two (#4 and #5) of nine sampled clients reviewed for resident assessments.<br><br>The BOM identified 27 residents resided in the center.<br><br>Findings:<br><br>1. Resident #4 had diagnoses which included, dementia, psychotic mood disturbance, and anxiety.<br><br>An undated "Annual Assessment," documented Resident #4 was alert but forgetful, confused at | C 522                                                                             |                                                                                                                          |                                                        |

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| C 522                                                         | <p>Continued From page 11</p> <p>times, and needed assistance of one staff for bathing and dressing. A slash mark was documented on toileting, transferring and ambulation. Resident #4 had occasional incontinence of bowel and bladder at times. The assessment was signed and dated by LPN #2 on 05/19/22.</p> <p>A "Behavior Note," dated 01/22/2023 at 5:18 a.m., read in part, "...CNA notified this nurse that [they] smelled burning in this residents room. Resident had placed a news paper in [their] microwave in an attempt to cook it...Microwave was removed..."</p> <p>A "Nursing Note," dated 02/07/23, read in parts, "...resident is having lot more confusion wandering off towards the memory care door looking for [their] room this am resident came to this writers door stating that [they] had not had anything to eat for days attempted to tell res [they] had just finished BKFST and [they] stated no..."</p> <p>A "Nursing Note," dated 02/09/23, read in parts, "...CNA reports that resident is opening multiple coffee pods in [their] room and adding just a little water to them and drinking it out of the pods..."</p> <p>A "Behavior Note," dated 02/24/23, read in parts, "...CNA reports resident uses the bathroom without assist and did not put clean brief on when done or remembered to clean self. Also reports resident hoarding utensils, food and snacks in room and will eat any leftover food that [the resident] takes to [their] room..."</p> <p>A "Behavior Note," dated 02/24/23, read in parts, "...CNA reports resident took coffee back to [the resident] room and emptied a coffee pod into [their] coffee and was drinking it with coffee</p> | C 522                                                                             |                                                                                                                          |                                                        |

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| C 522                                                         | <p>Continued From page 12</p> <p>grounds in it..."</p> <p>A "Nursing Note," dated 03/02/23, read in parts, "...CNA reports to this nurse that [they] went into residents room to check on [the resident] and [the resident] had bowel movement all other [sic] the bathroom floor and was wearing two briefs..."</p> <p>A "Nursing Note," dated 03/02/23, read in parts, "...CNA reports that resident is very incontinent of bowel and bladder..."</p> <p>A "Nursing Note," dated 03/10/23, read in parts, "...CNA reports to me that resident is hoarding coffee cups in [their] room. One cup that [CNA] found had coffee grounds in it and was growing mold..."</p> <p>On 03/09/23 at 7:20 a.m., Resident #4 was observed at the table eating breakfast. Resident #4 was spoken to but is HOH and did not respond.</p> <p>On 03/09/23 at 1:40 p.m., CNA #1 was asked what kind of assistance Resident #4 required for ADL's. They stated the resident required assistance of one staff for everything, except eating and the resident was totally incontinent. CNA #1 stated the resident has had a decline within the last year.</p> <p>On 03/09/23 at 3:26 p.m., the ADON was shown Resident #4's annual assessment, dated 05/19/22, and asked what did the slash marks mean on toileting, transferring and ambulation. The ADON was unsure. The ADON was asked if Resident #4 had a decline in [their] ADL status and should a significant change been done. The ADON stated, "Yes."</p> | C 522                                                                             |                                                                                                                          |                                                        |

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| C 522                                                         | <p>Continued From page 13</p> <p>On 03/13/23 at 3:00 p.m., the DON was asked when did they recognize Resident #4 had a decline in their ADL's. The DON stated, "A couple of months now." The DON stated, "[the resident] ends up at memory care and is lost, [the resident] was in here (tornado shelter with heavy metal doors), we heard knocking on the door. [The resident] couldn't get the door open."</p> <p>2. Resident #5 had diagnoses which included, high blood pressure, type two diabetes mellitus, and chronic kidney disease.</p> <p>An "Annual Assessment," dated 05/19/22, documented Resident #5 was alert to person place and time, and used a walker for ambulation. Resident #5 was independent with ADL's but did need assistance of one staff for bathing and was incontinent of bowel and bladder at times.</p> <p>On 03/09/22 at 1:35 p.m., CNA #1 was asked what assistance Resident #5 required for ADL's. CNA #1 stated, "One person physical assist, I have to tell [the resident] to lift [their ] leg, I do everything, toileting, wiping. [The resident] got COVID and never got back up to where [the resident] was."</p> <p>On 03/09/23 at 3:29 p.m., the ADON was shown Resident #5's assessment, dated 05/19/22, and asked what level of care did they require now. They stated, a Level 3. The ADON was asked if Resident #5 has had a decline in two or more ADL's that were not temporary and if a significant change should have been completed since 05/19/22. The ADON stated, "Yes."</p> | C 522                                                                             |                                                                                                                          |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>HERITAGE COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1401 N LELIA<br/>GUYMON, OK 73942</b> |                                                                                                                          |                                                        |
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| C 542                                                         | Continued From page 14                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | C 542                                                                             |                                                                                                                          |                                                        |
| C 542<br>SS=E                                                 | <p>310:663-5-4(b) CONDUCT OF ASSESSMENT</p> <p>(b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician.</p> <p>This Rule is not met as evidenced by:<br/>Based on record review, and interview, the center failed to ensure resident assessments were coordinated and signed by the Registered Nurse for three (#10, 6 and #7) of nine sampled residents reviewed for resident assessments.</p> <p>The BOM identified 27 residents resided in the center.</p> <p>Findings:</p> <p>1. Resident #10 had diagnoses which included, atrial fibrillation, and high cholesterol.</p> <p>Resident #10's "Preadmission Assessment," dated 12/19/22, had not been signed by a Registered Nurse.</p> <p>On 03/14/23 at 10:21 a.m., the DON was asked if the assessment had been signed by a Registered Nurse. The DON stated, "No."</p> <p>2. Resident #6 had diagnoses which included, chronic respiratory failure, type two diabetes mellitus, and rheumatoid arthritis.</p> <p>Resident #6's "Preadmission Assessment," dated 12/19/22, had not been signed by a Registered Nurse.</p> <p>On 03/14/23 at 11:00 a.m., the DON was asked if</p> | C 542                                                                             |                                                                                                                          |                                                        |



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| C 542                                                         | Continued From page 15<br><br>Resident #6's assessment had been signed by an Registered Nurse. The DON stated, "No."<br><br>3. Resident #7 was admitted on 02/03/23, with diagnosis to include dementia, anxiety, and current pathological fracture.<br><br>An undated, untimed, "Recommended Assisted Living Resident Assessment Form," had not been signed by the Registered Nurse.<br><br>On 03/14/23 at 11:30 a.m., the DON was asked if the staff signature identified as "ADON" was an RN. The DON stated, "No, that nurse was an LPN". The DON was asked if the form had been reviewed or signed by an RN or physician. The DON stated, "No." | C 542                                                                             |                                                                                                                          |                                                        |
| C 552<br>SS=E                                                 | 310:663-5-5(2) USE OF ASSESSMENT<br><br>The assisted living center shall use the results of the resident's assessment for the following:<br>(2) to develop a care plan for the resident, in consultation with the resident.<br><br>This Rule is not met as evidenced by:<br>Based on record review, and interview, the center failed to develop care plans for eight (#1, 2, 3, 4, 5, 6, 7 and #8) of eight sampled residents reviewed for care plans.<br><br>The BOM identified 27 residents resided in the center.                                                                                                                                 | C 552                                                                             |                                                                                                                          |                                                        |

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| C 552                                                         | <p>Continued From page 16</p> <p>Findings:</p> <p>1. Resident #3 had diagnoses which included, unspecified pulmonary fibrosis, and shortness of breath.</p> <p>An "Annual Assessment," dated 05/17/22, documented Resident #3 was alert to person, place and time, was independent with ADL's but did need standby assistance for bathing.</p> <p>Resident #3's clinical health record did not contain a care plan.</p> <p>2. Resident #4 had diagnoses which included, dementia, psychotic mood disturbance, and anxiety.</p> <p>An undated, "Annual Assessment," documented Resident #4 was alert but forgetful, confused at times and needed assistance of one staff for bathing and dressing. Resident #4 had occasional incontinence of bowel and bladder at times.</p> <p>Resident #4's clinical health record did not contain a care plan.</p> <p>3. Resident #5 had diagnoses which included, high blood pressure, type two diabetes mellitus, and chronic kidney disease.</p> <p>An "Annual Assessment," dated 05/19/22, documented Resident #5 was alert to person place and time, and used a walker for ambulation. Resident #5 was independent with ADL's but did need assistance of one staff for bathing and was incontinent of bowel and bladder at times.</p> | C 552                                                                             |                                                                                                                          |                                                        |

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| C 552                                                         | <p>Continued From page 17</p> <p>Resident #5's "Care Plan," dated 01/19/22, documented one focus had been developed that Resident #5 was at low risk for falls</p> <p>The Care Plan was not fully developed to reflect the resident's required assistance of staff to complete ADLs, or medications.</p> <p>4. Resident #6 had diagnoses which included, pulmonary fibrosis, type two diabetes mellitus and rheumatoid arthritis.</p> <p>A "Preadmission Assessment," dated 12/19/22, documented Resident #6 was "OK" with bathing. Assistance needed with eating, dressing, transferring, toileting and ambulation were left blank. Resident #6 was on oxygen from 3-10 liters and would self regulate.</p> <p>Resident #6's clinical health record did not contain a care plan.</p> <p>On 03/09/23 at 3:30 p.m., the ADON was asked if they were aware it was in the resident service contract that a care plan would be created after the assessment. The ADON stated, "No."</p> <p>On 03/13/23 at 12:40 p.m., the DON was asked if care plan's had been created for Resident #3, 4, 5, and #6. The DON stated, "No."</p> <p>5. Resident #1 had diagnoses to include Alzheimer's disease, and psychosis.</p> <p>An "Assessment," dated 09/14/22, documented Resident #1 required a front wheel walker for ambulation, utilized a wheelchair for long distances, required staff assistance for bathing, dressing, transfers and toileting, and required a</p> | C 552                                                                             |                                                                                                                          |                                                        |

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| C 552                                                         | <p>Continued From page 18</p> <p>breathing treatment via nebulizer daily.</p> <p>The clinical record contained no care plan.</p> <p>On 03/14/23 at 10:10 a.m., the DON was asked for Resident #1's care plan. The DON stated the resident did not have a care plan.</p> <p>6. Resident #2 had diagnoses to include altered mental status, dementia, delirium, history of a traumatic fracture, pain, history of falling, and hearing loss.</p> <p>An "Initial Admission" assessment, dated 05/17/22, documented Resident #2 required supervision for toileting, walking, ambulation, required limited assistance for dressing and personal hygiene, and required physical help in bathing.</p> <p>The clinical record contained no care plan.</p> <p>Resident #2 was readmitted from LTC on 08/25/22.</p> <p>The clinical record contained no care plan when Resident #2 was readmitted.</p> <p>On 03/14/23 at 9:40 a.m., the DON was asked if a care plan had been completed for Resident #2 while in AL. The DON stated, "No."</p> <p>7. Resident #7 had diagnoses to include dementia, anxiety disorder, hypertension, pathological fracture, GERD, reduced mobility, cognitive communication deficit, and a pressure ulcer of the right heel.</p> <p>An undated, untimed "Recommended Assisted Living Resident Assessment Form," documented</p> | C 552                                                                             |                                                                                                                          |                                                        |

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| C 552                                                         | Continued From page 19<br><br>Resident #7 was oriented to self, confused,<br>required staff assistance for ambulation, bathing,<br>eating, dressing, transferring, toileting, and had a<br>special diet order for ground foods.<br><br>The clinical record contained no care plan for<br>Resident #7.<br><br>On 03/14/23 at 11:30 a.m., the DON was asked<br>for Resident #7's care plan. The DON stated<br>Resident #7 did not have a care plan.<br><br>8. Resident #8 had diagnoses to include atrial<br>fibrillation, atherosclerotic heart disease, UTI, and<br>hypertension.<br><br>A "Recommended Assisted Living Resident<br>Assessment Form," dated 02/20/23, documented<br>Resident #8 was forgetful, required assistance<br>with bathing, transferring, toileting and<br>ambulation, required a walker for ambulation, and<br>was incontinent of bowel and bladder.<br><br>The clinical record did not contain a care plan for<br>Resident #8.<br><br>On 03/13/23 at 4:45 p.m., the DON was asked if<br>a care plan had been completed for Resident #8.<br>The DON stated, "No." | C 552                                                                             |                                                                                                                          |                                                        |
| C 711<br>SS=D                                                 | 310:663-7-1(a) GENERAL REQUIREMENTS<br><br>(a) Each assisted living center shall<br>comply with applicable construction<br>and safety standards pursuant to Title<br>74 O.S. Sections 317<br>through 324.21.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | C 711                                                                             |                                                                                                                          |                                                        |

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| C 711                                                         | <p>Continued From page 20</p> <p>This Rule is not met as evidenced by:<br/>Based on record review, and interview, the facility failed to ensure an annual fire inspection was completed.</p> <p>The BOM identified 27 residents resided in the center.</p> <p>Findings:</p> <p>On 03/08/23 at 2:19 p.m., a "[Name of City] Fire Department," inspection report, dated 12/29/21, was provided by the BOM. The BOM stated, "This 12/29/21 is for January 2022, [the Administrator] had it done before [they] left, we don't have one for 2023." The BOM stated, "I have called to schedule an inspection, they should be here on Friday."</p> <p>On 03/03/23 at 11:04 a.m., maintenance was asked who was responsible to ensure a Fire Marshall inspection was completed. They stated, the Administrator did it. They were asked if that is why one had not been done since the Administrator left. They stated, yes.</p> <p>No documentation was provided a Fire Marshall inspection had been completed since 12/29/2021.</p> | C 711                                                                             |                                                                                                                          |                                                        |

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| C 911                                                         | Continued From page 21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | C 911                                                                             |                                                                                                                          |                                                        |
| C 911<br>SS=E                                                 | <p>310:663-9-1(1) NURSE</p> <p>Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:</p> <p>(1) registered nurse supervision of skilled nursing interventions;</p> <p>This Rule is not met as evidenced by:<br/>Based on record review, and interview, the facility failed to ensure RN supervision to monitor physician orders were followed to include:</p> <p>a. medications were administered as ordered for two ( #1 and #8) of nine residents reviewed for medications, and</p> <p>b. weekly wound monitoring was completed for one (#7) of three residents reviewed for weekly wound monitoring.</p> <p>Findings:</p> <p>1. Resident #1 had diagnoses to include Alzheimer's disease, hypertension, hypothyroidism, hyperlipidemia and psychosis.</p> | C 911<br><br>C 911                                                                |                                                                                                                          |                                                        |



Oklahoma State Department of Health

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| C 911                                                         | <p>Continued From page 22</p> <p>A "Physician Order," dated 09/17/22, documented Resident #1 was to be administered Losartan Potassium -HCTZ 100-25 mg daily for hypertension. The order did not contain parameters to hold the medication.</p> <p>The "Medication Administration Record," dated October 2022, documented Losartan was held four times due to a low blood pressure.</p> <p>The "Medication Administration Record," dated November 2022, documented Losartan was held four times due to a low blood pressure.</p> <p>The "Medication Administration Record," dated December 2022, documented Losartan was held three times due to a low blood pressure.</p> <p>A "Physician Order," dated 01/03/23, documented Resident #1 was to be administered Losartan Potassium-HCTZ 100-25 mg daily for hypertension. The medication was to be held if the systolic blood pressure was below 100.</p> <p>The "Medication Administration Record," dated January 2023, documented Losartan was held three times due to a low blood pressure. The MAR documented the systolic blood pressures to be greater than 100 as directed in the physician order.</p> <p>The "Medication Administration Record," dated February 2023, documented Losartan was held six times due to a low blood pressure. The MAR documented the systolic blood pressures to be greater than 100 for five times and a blood pressure was not documented for one time.</p> <p>The "Medication Administration Record," dated</p> | C 911                                                                             |                                                                                                                          |                                                        |

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| C 911                                                         | <p>Continued From page 23</p> <p>March 2023, documented Losartan was held once for a low blood pressure. The MAR documented the systolic blood pressure to be greater than 100 as directed in the physician order</p> <p>Resident #1 had not been administered Losartan for a total of 21 times, from 10/03/22 through 03/07/23. The medication had been held without a physician order to hold the medication 12 doses, and the Resident's blood pressure did not meet criteria for the Losartan to be held for seven doses.</p> <p>The clinical record contained no documentation the physician had been notified or consulted the Losartan had been held for a total of 21 doses.</p> <p>On 03/14/23 at 10:10 a.m., the DON was shown the progress notes and MAR regarding medications not administered as ordered, and held without parameters. The DON stated they were not aware the medications were not administered per the physician's orders.</p> <p>2. Resident #7 was admitted to the facility with a diagnosis of a pressure ulcer of the right heel with an unspecified stage.</p> <p>A "Progress Note," dated 02/03/23, read in parts, "...arrived with family...using walker and wheelchair...may also be pushed in wheelchair at times due to pressure ulcer on right heel...Measuring 1.8 inches long and 1.5 inches wide...currently closed with black eschar present..."</p> <p>A "Physician Order," dated 02/07/23, documented Resident #7 was to have a weekly skin assessment completed every Friday.</p> | C 911                                                                             |                                                                                                                          |                                                        |

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| C 911                                                         | <p>Continued From page 24</p> <p>A "Weekly Skin Assessment," dated 02/03/23, documented Resident #7 had a right heel pressure wound with 1.8 length by 1.5 width, with lesions to the upper back, and a pressure ulcer to right heel was present upon arrival.</p> <p>A "Weekly Skin Assessment," dated 02/17/23, read in parts, "...Pressure ulcer to right heel which was there upon admission...continues to have black eschar and remains closed..."</p> <p>The clinical record contained no additional weekly skin assessments or wound assessments. Resident #7 had not been assessed for skin conditions on 02/10/23, 02/24/23 or 03/03/23 per the physician orders to be completed every Friday.</p> <p>On 03/09/23 at 2:35 p.m., LPN #1 was asked to allow the surveyor to view the wound and for the LPN to obtain measurements. LPN #1 provided wound care and measured the right heel wound to be 1.9 x 1.8, with black eschar. LPN #1 was asked how often the pressure wound was to be assessed and measured. The LPN stated they were not sure if there is not an order. LPN #1 was asked if a measurement was obtained with each skin assessment. LPN #1 stated they did not know and would have to ask someone. LPN #1 was asked if the physician had been notified the current treatment had not shown improvement in the wound. LPN #1 stated, the physician should have been notified if the wound had not improved within a week or two due to the resident having been on the same treatment prior to admission.</p> <p>On 03/14/23 at 11:30 a.m., the DON was informed of the pressure wound without adequate</p> | C 911                                                                             |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C 911                                                         | <p>Continued From page 25</p> <p>assessment per they physician orders. The DON stated the facility had some work to do.</p> <p>3. Resident #8 had diagnoses to include atrial fibrillation, atherosclerotic heart disease, and hypertension.</p> <p>A "Physician Order," dated 02/20/23, documented Resident #8 was to be administered Lopressor 50 mg twice a day for hypertension.</p> <p>A "Physician Order," dated 02/20/23, documented Resident #8 was to be administered furosemide 40 mg twice a day for hypertension.</p> <p>A "Physician Order," dated 02/21/23, documented Resident #8 was to be administered furosemide 40 mg daily for swelling related to hypertension.</p> <p>The physician orders did not contain parameters to which the Lopressor or furosemide were to be held/not administered.</p> <p>The "Medication Administration Record," dated 02/2023, documented furosemide was not administered twice, and Lopressor was not administered eight doses, due to low blood pressure.</p> <p>The "Medication Administration Record," dated 03/2023, documented furosemide was not administered three doses and Lopressor was not administered 17 doses due to low blood pressure.</p> <p>The clinical record did not contain documentation the physician was notified/consulted the furosemide and Lopressor were being held due to low blood pressure.</p> <p>On 03/13/23 at 4:45 p.m., the DON was asked if</p> | C 911                                                                             |                                                                                                                          |                                                        |

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| C 911                                                         | Continued From page 26<br><br>the orders for furosemide or Lopressor contained parameters or directions to indicate the medication was to be held. The DON stated, "No." They stated they should have notified the physician and clarified the order to have hold parameters or to be discontinued. The DON stated they were not aware the medications were being held with out a physician order.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | C 911                                                                             |                                                                                                                          |                                                        |
| C 930<br>SS=F                                                 | 310:663-9-3(1-3) STAFF QUALIFICATIONS<br><br>Each assisted living center shall designate an administrator responsible for the operation of the assisted living center. The administrator shall hold at least one (1) of the following credentials:<br>(1) a license issued by the State Board of Examiners for Nursing Home Administrators; or<br>(2) a residential care home administrator's certificate of training from an institution of higher learning whose program has been reviewed by the Department; or<br>(3) a nationally recognized assisted living certicate of training and competency for assisted living administrators that has been reviewed and approved by the Department.<br><br>This Rule is not met as evidenced by:<br>Based on record review, and interview, the center failed to ensure an assisted living administrator was designated for the operation of the assisted living center. | C 930                                                                             |                                                                                                                          |                                                        |

Oklahoma State Department of Health  
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Oklahoma State Department of Health

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| C1301                                                         | <p>Continued From page 28</p> <p>Based on record review, and interview, the center failed to ensure the resident or resident representative was provided with a complete and understandable copy of the resident service contract for seven (#1, 2, 3, 4, 6, 7, and #8) of seven sampled residents contracts reviewed.</p> <p>The BOM identified 27 residents resided in the center.</p> <p>Findings:</p> <p>Resident #3, #4, and #6 resident service contracts did not contain documentation the resident or representative had been provided with a complete and understandable copy of the resident service contract.</p> <p>On 03/09/23 at 2:33 p.m., SS was asked if Resident #4's contract contained the resident or representative had been provided a copy of the contract. SS reviewed the service agreement and stated, "No."</p> <p>On 03/09/23 at 2:44 p.m., SS was asked if Resident #6's contract contained the resident or representative had been provided a copy of the contract. SS reviewed the service agreement and stated, "No."</p> <p>On 03/09/23 at 2:48 p.m., SS was asked if Resident #3's contract contained the resident or representative had been provided a copy of the contract. SS reviewed the service agreement and stated, "No."</p> <p>2. Residents #1, 2, 7 and #8 resident service contracts did not contain documentation the resident or their representative have been provided a complete and understandable copy of</p> | C1301                                                                             |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C1301                                                         | Continued From page 29<br><br>the residents' service contract.<br><br>On 03/13/23 at 4:45 p.m., the DON was asked if<br>a complete and understandable copy of the<br>resident's service contract had been provided to<br>Resident #8 or their family. The DON stated,<br>"No."<br><br>On 03/14/23 at 9:40 a.m., the DON was asked if<br>a complete and understandable copy of the<br>resident's service contract had been provided to<br>Resident #2 or their family. The DON stated,<br>"No."<br><br>On 03/14/23 at 10:10 a.m., the DON was asked if<br>a complete and understandable copy of the<br>resident's service contract had been provided to<br>Resident #1 or their family. The DON stated,<br>"No."<br><br>On 03/14/23 at 11:30 a.m., the DON was asked if<br>a complete and understandable copy of the<br>resident's service contract had been provided to<br>Resident #7 or their family. The DON stated,<br>"No." | C1301                                                                             |                                                                                                                          |                                                        |
| C1303<br>SS=E                                                 | 310:663-13-1(c) RESIDENT SERVICE<br>CONTRACT<br><br>(c) The assisted living center shall ensure that<br>the resident or the resident's representative, if<br>any, is informed of all provisions of the resident<br>service contract.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | C1303                                                                             |                                                                                                                          |                                                        |



Oklahoma State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL7001</b>        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/14/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HERITAGE COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1401 N LELIA<br/>GUYMON, OK 73942</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C1303                                                         | <p>Continued From page 30</p> <p>This Rule is not met as evidenced by:<br/>Based on record review, and interview the center failed to ensure residents or representatives were informed of all the provisions of the resident service agreement contract for seven (#1, 2, 3, 4, 6, 7, and #8) of seven sampled residents reviewed for contracts.</p> <p>The BOM identified 27 residents resided in the center.</p> <p>Findings:</p> <p>Resident #3, #4 and #6 resident service agreements did not contain the resident or representative had been informed of all provisions of the resident service agreement contract.</p> <p>On 03/09/23 at 2:33 p.m., SS was asked if Resident #4's contract contained the resident or representative had been informed of all the provisions of the contract. SS reviewed the service agreement and stated, "No."</p> <p>On 03/09/23 at 2:44 p.m., SS was asked if Resident #6's contract contained the resident or representative had been informed of all the provisions of the contract. SS reviewed the service agreement and stated, "No."</p> <p>On 03/09/23 at 2:48 p.m., SS was asked if Resident #3's contract contained the resident or representative had been informed of all the provisions of the contract. SS reviewed the service agreement and stated, "No."</p> | C1303                                                                             |                                                                                                                          |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL7001</b>        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/14/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HERITAGE COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1401 N LELIA<br/>GUYMON, OK 73942</b> |                                                                                                                          |                                                        |
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| C1303                                                         | Continued From page 31<br><br>2. Residents #1, 2, 7, and #8 resident service agreements did not contain the resident or representative have been informed of all provision of the residents service agreement contract.<br><br>On 03/13/23 at 4:45 p.m., the DON was asked if Resident #8's contract agreement contained the resident or representative had been informed of all of the provision of the contract. The DON state, "No."<br><br>On 03/14/23 at 9:40 a.m., the DON was asked if Resident #2's contract agreement contained the resident or representative had been informed of all of the provision of the contract. The DON state, "No."<br><br>On 03/14/23 at 10:10 a.m., the DON was asked if Resident #1's contract agreement contained the resident or representative had been informed of all of the provision of the contract. The DON state, "No."<br><br>On 03/14/23 at 11:30 a.m., the DON was asked if Resident #7's contract agreement contained the resident or representative had been informed of all of the provision of the contract. The DON state, "No." | C1303                                                                             |                                                                                                                          |                                                        |
| C1304<br>SS=E                                                 | 310:663-13-1(d) RESIDENT SERVICE CONTRACT<br><br>(d) The assisted living center shall provide all services that are specified in the resident's current service contract.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | C1304                                                                             |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>HERITAGE COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1401 N LELIA<br/>GUYMON, OK 73942</b> |                                                                                                                          |                                                        |
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| C1304                                                         | <p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review, observation, and interview the center failed to provide services as stated in the resident's service contract to</p> <ul style="list-style-type: none"> <li>a. complete a self administration assessment for one (#3) of one sampled residents who self administered breathing treatments, and</li> <li>b. ensure medications were ordered and available to administer for four (#1, 2, 7, and #8) of eight sampled residents reviewed for medications.</li> </ul> <p>The BOM identified 27 residents resided in the center.</p> <p>Findings:</p> <ul style="list-style-type: none"> <li>1. Resident #3 had diagnoses which included, unspecified pulmonary fibrosis and shortness of breath.</li> </ul> <p>Resident #3's "Assisted Living Resident Service Contract," dated 06/30/21, read in part,<br/>"...Pharmacy &amp; Medication Management...Self-Administration of Medication:<br/>The RN will conduct an assessment to determine if the resident can safely administer his or her own medication. This assessment will be conducted on admission, monthly, or after a</p> | C1304                                                                             |                                                                                                                          |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>HERITAGE COMMUNITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1401 N LELIA<br/>GUYMON, OK 73942</b> |                                                                                                                          |                                                        |
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| C1304                                                         | <p>Continued From page 33</p> <p>significant change in the resident's health status..."</p> <p>An "Annual Assessment," dated 05/17/22, documented Resident #3 was alert to person, place and time and was independent with ADL's but required standby assistance with bathing.</p> <p>A "Physician Order," dated 12/21/22, read in part, "...Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally three times a day related to PULMONARY FIBROSIS, UNSPECIFIED unsupervised self-administration..."</p> <p>On 03/09/23 at 9:53 a.m., LPN #1 was asked if residents are assessed if they self medicate. LPN #1 stated, "No, we just have to have an order."</p> <p>On 03/09/23 at 10:56 a.m., Resident #4 was asked if they completed their breathing treatments by themselves. They stated, "Yes."</p> <p>On 03/13/23 at 12:40 p.m., the DON was asked if they had completed an assessment for Resident #3 to self administer their breathing treatments. The DON stated, "No." The DON was asked if they were aware the resident contract stated an assessment would be completed. The DON stated, "No."</p> <p>2. Resident #1 was admitted to the facility on 09/16/22 with diagnoses to include hypothyroidism, anxiety, hyperlipidemia, and COVID-19.</p> <p>An "Assisted Living Resident Service Contract," dated 09/20/22, read in parts, "...All medications that are to be administered...will be provided to the facility. Delivery of medications...will be coordinated so that there is no delay in</p> | C1304                                                                             |                                                                                                                          |                                                        |

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| C1304                                                         | <p>Continued From page 34</p> <p>administration of medication..."</p> <p>A "Physician Order," dated 09/20/22, documented Resident #1 was to be administered buspirone 5 mg every day for anxiety, and 5 mg administered two tablets every afternoon at 4:00 p.m.</p> <p>A "Physician Order," dated 09/21/22, documented Resident #1 was to be administered levothyroxine 75 mcg every morning for hypothyroidism.</p> <p>A "Physician Order," dated 09/22/22, documented Resident #1 was to be administered lorazepam 0.5 mg at bedtime for anxiety.</p> <p>The "Medication Administration Record," dated 09/2022, documented Levothyroxine was not available on 09/21/22.</p> <p>The "Medication Administration Record," dated 10/2022, documented:</p> <p>a. buspirone was not available for two doses; and</p> <p>b. lorazepam was not available for two doses.</p> <p>The "Medication Administration Record," dated 11/2022, documented buspirone was not available for three doses.</p> <p>The "Medication Administration Record," dated 12/2022, documented buspirone was not available for one dose.</p> <p>A "Progress Note," dated 01/03/23, documented Resident #1 was positive for COVID-19.</p> <p>A "Physician Order," dated 01/03/23, documented Resident #1 was to be administered DayQuil Severe + VapoCool Liquid 5-10-200-325 mg/15 ml, administer 15 ml routinely two times a day for</p> | C1304                                                                             |                                                                                                                          |                                                        |

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| C1304                                                         | <p>Continued From page 35</p> <p>cough.</p> <p>A "Progress Note," dated 01/11/23 at 6:14 a.m., documented DayQuil was not available.</p> <p>A "Progress Note, dated 01/11/23 at 12:12 p.m., documented DayQuil was not available.</p> <p>On 03/14/23 at 10:10 a.m., the DON was asked to review the physician orders, progress notes, and MARS regarding medications not available. The DON stated the medication aide should have reported the medications were not available and a licensed nurse should have called the pharmacy to obtain the medications.</p> <p>3. Resident #2 had diagnoses to include altered mental status, delirium, dementia, hypothyroidism, hypertension, peripheral vascular disease, and constipation.</p> <p>An "Assisted Living Resident Service Contract," dated 08/25/22, read in parts, "...All medications that are to be administered...will be provided to the facility. Delivery of medications...will be coordinated so that there is no delay in administration of medication..."</p> <p>"Physician Orders," dated 08/25/22, documented Resident #2 was to be administered:</p> <ul style="list-style-type: none"> <li>a. metoprolol 25 mg daily for hypertension. The order instructed to hold the medication if the systolic blood pressure was less than 100;</li> <li>b. Levothyroxine 25 mcg once a day for hypothyroidism;</li> <li>c. famotidine 20 mg at bedtime for a gastric ulcer;</li> <li>d. Ocuville daily; and</li> <li>e. Tylenol 8 Hour extended release 650 mg, one tablet at bedtime and two tablets in the morning</li> </ul> | C1304                                                                             |                                                                                                                          |                                                        |

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| C1304                                                         | <p>Continued From page 36</p> <p>for pain.</p> <p>"Physician Orders," dated 08/26/22, documented Resident #2 was to be administered:</p> <ul style="list-style-type: none"> <li>a. colace 100 mg twice a day for constipation; and</li> <li>b. two tablets of Risperidone 0.25 mg one time a day for delirium.</li> </ul> <p>The "Medication Administration Record," dated 09/2022, documented:</p> <ul style="list-style-type: none"> <li>a. metoprolol was not available for 19 doses;</li> <li>b. Levothyroxine was not available for 22 doses; and</li> <li>c. colace was not available for two doses.</li> </ul> <p>The "Medication Administration Record," dated 10/2022, documented:</p> <ul style="list-style-type: none"> <li>a. metoprolol was not available for five doses;</li> <li>b. Levothyroxine was not available for five doses;</li> <li>c. colace was not available for two doses; and</li> <li>d. Ocuvite was not available for one dose.</li> </ul> <p>The "Medication Administration Record," dated 11/2022, documented:</p> <ul style="list-style-type: none"> <li>a. Famotidine was not available for one dose; and</li> <li>b. Risperdone was not available for six doses.</li> </ul> <p>A "Physician Order," dated 12/02/22, documented Resident #2 was to have docusate sodium liquid, four drops instilled in both ears at bedtime for ear wax, administer for three days.</p> <p>The "Medication Administration Record," dated 12/2022, documented:</p> <ul style="list-style-type: none"> <li>a. metoprolol was not available for one dose;</li> <li>b. Levothyroxine was not available for one dose;</li> <li>c. famotidine was not available for one dose;</li> <li>d. Docusate sodium liquid was not available for</li> </ul> | C1304                                                                             |                                                                                                                          |                                                        |