

Delivery via email to: hre-ed@12oaks.net

February 14, 2024

License Number: AL7203

Ms. Lauren 'Paige' Luker, Administrator
Heatheridge Assisted Living
2130 South 85th East Avenue
Tulsa, OK 74129

RE: Survey Event ID: 4NEJ11

Dear Ms. Luker:

On **February 5, 2024**, 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 **February 5, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/05/2024
NAME OF PROVIDER OR SUPPLIER HEATHERIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2130 SOUTH 85TH EAST AVENUE TULSA, OK 74129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted from 02/01/24, 02/02/24, and 02/05/24. Facility Census: 77 Listed below are abbreviations that will be used throughout this document. DA - dietary aide DM - dietary manager Res - resident	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure food was stored, prepared, and served in a sanitary manner. The "Assisted Living Resident Condition and Care Overview" form documented a census of 77 residents who resided in the center at the time of the survey. Findings: On 02/01/24 at 4:03 p.m., an observation of the kitchen, storage areas, refrigerators, freezers, evening meal preparation and service, was observed. DA #1 was observed entering the kitchen wearing a ball cap, having approximately 1/4 inch beard stubble, and no beard guard. The	C 391		

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 391	Continued From page 1 DA did not wash hands on entry to the kitchen area prior to starting serving and preparing meals. The cook was observed to have on a cloth hair covering which did not contain their hair completely. The DM was observed with a hair net on which had slipped back and did not contain their hair. A small cooler/refrigerator in the kitchen area was observed with a container of raw chicken breast in a container of water. A label on the container documented a date of 01/30/24. A small plastic container was observed with a clear liquid in the small refrigerator. The container did not have a label of contents or date. The large walk-in freezer was observed to have box of biscuits which was open to air and sitting on the floor. In the walk-in refrigerator was observed to have a plastic container full of shelled hard-boiled eggs soaking in water. The container did not have a date when the eggs were prepared. A large plastic container of raw chicken breasts soaking in buttermilk and covered with plastic wrap with a label of 01/31/24 was observed sitting on a rack in the refrigerator. The dry storage pantry was observed to have four bowls of dry cereal poured with no covers or date labels. DA #1 was observed picking up a bag of hamburger buns off the floor where they had fallen and placed them back on the shelf for use. Later, during this observation, the DA was observed to prepare a hamburger using the buns in the bag.	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 2 An unidentified CNA was observed entering the kitchen with no hair net on and without washing their hands. They were observed to have obtained a meal in a styrofoam container and then left the kitchen. DA #1 was observed using gloved hands throughout the observation of the meal service. The DA was not observed to doff the gloves, wash hands, and re-glove their hands when the gloves became contaminated. One observation included the DA picking up shredded lettuce, along with other salad toppings, with the gloved hands, and placed the salad mixture into a bowl for service to a resident. On 02/01/23 at 4:42 p.m., the DM stated they were not a certified dietary manager. They confirmed the whole eggs the facility utilized were un-pasteurized. The DM stated they did not know the unpasteurized eggs could not be pooled. They stated the hard-boiled eggs in the walk-in refrigerator were unpasteurized. The DM stated they did not know when the eggs had been prepared but thought it was earlier in the day. The DM stated the unlabeled container of clear liquid in the small refrigerator was a container of egg whites the staff had cracked, pooled, and placed in a plastic container for a resident who only ate egg whites. The DM confirmed the egg whites should not have been pooled. The DM was asked about the raw chicken soaking in water, dated 01/30/24, and the raw chicken soaking in buttermilk, dated 01/30/24. They stated the chicken should have been disposed of when it was not used. The DM was asked about the staff wearing gloves and not washing hands. They stated the staff should have removed their gloves when ever they became contaminated,	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 3 washed their hands, and donned clean gloves. The DM confirmed the staff should have not used their hands to pick up lettuce and salad fixings. The DM stated the bag of buns, which had fallen on the floor, would have been ok to use if the buns had not touched the floor. When asked what would happen if the staff handled the bag and then reached inside to grab a bun the DM stated the bag should have been thrown away when it fell on the floor. The DM stated staff should have washed their hands and donned a hairnet when they entered the kitchen area. They confirmed the entry to the kitchen was the external kitchen door marked "in". The DM stated the unidentified staff member who entered the kitchen without a hair net should have donned a hair net and washed their hands when entering the kitchen. When asked about the staff hair coverings not completely covering their hair, they stated they should have their hair contained. When asked about the DA with a short beard, the DM stated the beard was short the DA did not need a beard net and only staff members with long beards would need one. The DM stated the cereal in the pantry should have been covered and dated. On 02/01/24 at 5:20 p.m., the executive director confirmed all staff should have washed hands when entering the kitchen and whenever they became contaminated. They stated all staff should have had their hair contained, including beard guards for staff members with facial hair regardless of the length of the facial hair. The executive director stated the raw chicken should have been disposed of and not refrigerated for possible future use and any food or packages of food which fell on the floor should have been disposed. The administrator stated staff members should have removed gloves, washed	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 4 their hands, and donned clean gloves when they have handled anything which could have been considered contaminated and/or to prevent cross contamination. They confirmed all food dispensed and held for later service should have been covered and labeled. The administrator confirmed when un-pasteurized eggs were used they should not have been pooled or stored in an unsafe manner.	C 391		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a registered nurse or the residents' physician signed the resident assessment for three (#3, 4, and #7) of ten residents whose assessments were reviewed. The "Assisted Living Resident Condition and Care Overview" documented a census of 77 residents living in the center. Findings: An admission assessment for Res #4, dated 06/02/23, did not document the signature of a registered nurse or the resident's physician. An admission assessment for Res #7, dated 08/23/23, did not document the signature of a registered nurse or the resident's physician.	C 542		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER HEATHERIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2130 SOUTH 85TH EAST AVENUE TULSA, OK 74129		
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C 542	Continued From page 5 A significant change assessment for Res #3, dated 02/01/24, did not document the signature of a registered nurse or the resident's physician. On 02/05/24 at 2:15 p.m., the administrator reviewed the assessments for Res #3, 4, and #7 and confirmed neither the registered nurse or the residents' physician had signed the assessments. On 02/05/24 at 3:33 p.m., the administrator stated they spoke with the registered nurse who should have signed the assessments. The administrator stated the assessments should have been signed as the registered nurse was employed by the facility at the time the assessments were completed.	C 542		

Delivery via email to: hre-ed@12oaks.net

February 28, 2024

License Number: AL7203

Ms. Lauren Luker, Administrator
Heatheridge Assisted Living
2130 South 85th East Avenue
Tulsa, OK 74129

RE: Survey Event 4NEJ11

Dear Ms. Luker:

On **February 5, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **March 15, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 2/27/2024

Facility Name: Heatheridge Assisted Living

License Number: AL7203

Survey Event ID: 4NEJ11

Date Survey Completed: 2/5/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: C391: Observation and review, the center failed to ensure food was prepared, stored, and served in a sanitary manner.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

C391: ED or designee will monitor food preparation, service, and storage to ensure compliance with Chapter 257 periodically each month for one quarter.

C391: ED or designee will monitor food preparation, service, and storage to ensure compliance with Chapter 257 periodically each month for one quarter.

C391: ED or designee will in-service all dietary staff over proper hand-washing procedures, food preparation, service and storage in accordance with Chapter 257 Food Service Manual, and hair net requirements quarterly.

C391:ED or designee will in-service all dietary staff over proper hand-washing procedures, food preparation, service and storage in accordance with Chapter 257 Food Service Manual, and hair net requirements quarterly.

C391:ED or designee will in-service all dietary staff over proper hand-washing procedures, food preparation, service and storage in accordance with Chapter 257 Food Service Manual, and hair net requirements quarterly.

C391: ED or designee will ensure staff are properly trained in accordance with save food storage, service and preparation by ensuring that training has taken place and food handlers permit is on file and will be reviewed quarterly through QA.

C391: ED or desinee will keep a log of dietary staff in-services for one quarter, ensuring that food service staff

		are trained in accordance with safe food storage, service and preparation.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Lauren Luker OAC 310:663-25-4(F)		Date 2/27/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 2/27/2024	
	Facility Name: Heatheridge Assisted Living	
	License Number: AL7203	
	Survey Event ID: NEJ11	
	Date Survey Completed: 2/5/2024	
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C542	Based on: Based on: C542: Record review and interview, the center failed to ensure a registered nurse of the residents' physician signed the resident assessment for (#3,#4,#7) of ten residents whose assessments were reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		C542: ED or designee will inservice Resident Care Director over OAC 310:663-5-4 – Assessment and Signature Requirements, and keep a log of existing resident assessments and new resident assessments to ensure signatures are obtained.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		C542: ED or designee will inservice Resident Care Director over OAC 310:663-5-4 – Assessment and Signature Requirements, and keep a log of existing resident assessments and new resident assessments to ensure signatures are obtained.
OSDH Response: Element accepted Yes ☐ No ☐		
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		C542: ED or designee will inservice Resident Care Director over OAC 310:663-5-4
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		C542: ED or designee will inservice Resident Care Director over OAC 310:663-5-4 – Assessment and Signature Requirements, and keep a log of existing resident assessments and new resident assessments to ensure signatures are obtained.
a. How the correction will be evaluated for effectiveness;		
b. How the correction will be incorporated into the center's quality assurance system; and		C542: ED or designee will inservice Resident Care Director over OAC 310:663-5-4 – Assessment and Signature Requirements, and keep a log of existing resident assessments and new resident assessments to ensure signatures are obtained.
c. How monitoring records will be kept to evidence the correction.		C542: ED or designee will inservice Resident Care Director over OAC 310:663-5-4 – Assessment and Signature Requirements, and keep a log of existing resident assessments and new resident assessments to ensure signatures are obtained.

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OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Lauren Luker OAC 310:663-25-4(F)		Date 2/27/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
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Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

Delivery via email to: hre-ed@12oaks.net

April 17, 2024

License Number: AL7203

Ms. Lauren Paige Luker, Administrator
Heatheridge Assisted Living
2130 South 85th East Avenue
Tulsa, OK 74129

RE: Survey Event ID: 4NEJ12

Dear Ms. Luker:

Enclosed is the summary of deficiencies following the revisit of a State Licensure survey conducted at your Assisted Living Center on **April 15, 2024**. These deficiencies remain uncorrected from our original inspection conducted **February 5, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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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.

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Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process



If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

A handwritten signature in black ink that reads "Lisa Calvin". The signature is written in a cursive, flowing style.

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/15/2024
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NAME OF PROVIDER OR SUPPLIER HEATHERIDGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2130 SOUTH 85TH EAST AVENUE TULSA, OK 74129
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS A revisit was conducted on 04/15/24 Facility Census: 77 Listed below are abbreviations that will be used throughout this document. DM - Dietary Manager	{C 000}		
{C 391} SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure food was stored, prepared and served in a sanitary manner. The administrator reported 77 residents resided in the center. Findings: On 4/15/24 at 9:30 a.m., an observation of the kitchen, storage areas, refrigerators, and freezer were made. The cook was observed without a hair net On 04/15/24 at 9:35 a.m., in the walk-in refrigerator was observed two plastic containers of cantaloupe, four plastic containers of sliced tomatoes, one plastic container of pickles, and two plastic containers of shredded lettuce covered with plastic wrap without labels or dates.	{C 391}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/15/2024
NAME OF PROVIDER OR SUPPLIER HEATHERIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2130 SOUTH 85TH EAST AVENUE TULSA, OK 74129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 391}	Continued From page 1 On 04/15/24 at 10:00 a.m. the DM stated the cantaloupe, tomatoes, pickles, and lettuce were prepared this morning and should have been labeled and dated. The DM stated hair nets are required and should be worn. 04/15/24 at 3:40 p.m. the Executive Director confirmed all staff should be wearing a hair net. They confirmed all food prepared for later use should have been labeled.	{C 391}		

Delivery via email to: Paige Luker <hre-ed@12oaks.net>

April 25, 2024

License Number: AL7203

Ms. Lauren 'Paige' Luker, Administrator
Heatheridge Assisted Living
2130 South 85th East Avenue
Tulsa, OK 74129

RE: Survey Event 4NEJ12

Dear Ms. Luker:

On **April 15, 2024**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C0391-** The facility's plan of correction did not address how the Quality Assurance Committee would be involved in assuring the measures put in place were effective.

Please provide an AMENDED plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 4/22/2024	
	Facility Name: Heatheridge Assisted Living	
	License Number: AL7203	
	Survey Event ID: 4NEJ12	
Date Survey Completed: 4/15/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C391	Based on: This STANDARD is not met as evidenced by: {C 391} Based on observation and interview, the center failed to ensure food was stored, prepared and served in a sanitary manner.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter.
OSDH Response: Element accepted Yes ☐ No ☐		
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained?		DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage

Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/6/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Lauren Paige Luker OAC 310:663-25-4(F)		Date 4/22/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text.](#)

Facility in Compliance by: [Click here to enter a date.](#)

Delivery via email to: Paige Luker <hre-ed@12oaks.net>

April 26, 2024

License Number: AL7203

Ms. Lauren Paige Luker, Administrator
Heatheridge Assisted Living
2130 South 85th East Avenue
Tulsa, OK 74129

RE: Survey Event 4NEJ12

Dear Ms. Luker:

On **April 15, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your Amended plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 6, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/25/2024

Facility Name: Heatheridge Assisted Living

License Number: AL7203

Survey Event ID: 4NEJ12

Date Survey Completed: 4/15/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: This STANDARD is not met as evidenced by: {C 391} Based on observation and interview, the center failed to ensure food was stored, prepared and served in a sanitary manner.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. This will be reviewed quarterly through QAPI.

DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. This will be reviewed quarterly through QAPI.

DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. This will be reviewed quarterly through QAPI.

OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. This will be reviewed quarterly through QAPI. DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. This will be reviewed quarterly through QAPI. DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. This will be reviewed quarterly through QAPI. DM or designee will keep a log of pre-prepared foods, and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual to ensure that all food items are appropriately labeled/dated. DM will ensure all staff are properly dressed each day with hairnet/haircovering with no loose hairs. DM will inservice dietary staff monthly on food storage, preparation and service. ED will monitor log for compliance every day for thirty days as applicable, monthly for one quarter, and one quarter thereafter. This will be reviewed quarterly through QAPI.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/6/2024
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Lauren Paige Luker	Date 4/22/2024

OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	4/25/2024	Submitted by	Lauren Paige Luker
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

Delivery via email to: hre-ed@12oaks.net

May 20, 2024

License Number: AL7203

Ms. Lauren Paige Luker, Administrator
Heatheridge Assisted Living
2130 South 85th East Avenue
Tulsa, OK 74129

RE: Survey Event ID: 4NEJ13

Dear Ms. Luker:

Enclosed is the summary of deficiencies following the revisit of a State Licensure survey conducted at your Assisted Living Center on **May 9, 2024**. These deficiencies remain uncorrected from our original inspection conducted **February 5, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance.

However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies. If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process



If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

A handwritten signature in black ink that reads "Lisa Calvin".

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/09/2024
NAME OF PROVIDER OR SUPPLIER HEATHERIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2130 SOUTH 85TH EAST AVENUE TULSA, OK 74129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS A revisit was conducted on 05/09/24. Census: 77 Listed below are abbreviations that will be used throughout this document. DA - dietary aide DM - dietary manager	{C 000}		
{C 391} SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure food was stored and prepared in a sanitary manner. The administrator identified 77 residents resided in the center. Findings: On 05/09/24 at 8:57 a.m., DA #1 was observed to not be wearing a hairnet while sorting silverware in the kitchen. DA #2 was observed to be wearing a ball cap and a beard guard. The beard guard was observed to not cover the hair on their upper lip. On 05/09/24 at 9:00 a.m., nine cereal bowls were observed to contain cereal, stacked one on top of another, uncovered and undated. On 05/09/24 at 9:08 a.m., large serving	{C 391}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/09/2024
NAME OF PROVIDER OR SUPPLIER HEATHERIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2130 SOUTH 85TH EAST AVENUE TULSA, OK 74129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 391}	Continued From page 1 containers for tea and a yellow drink were observed in the walk-in refrigerator unlabeled and undated. On 05/09/24 at 9:10 a.m., Cook #1 was observed to doff gloves, enter the walk-in and returned with strawberries and grapes in containers. Cook #1 donned gloves and moved the large rolling trash can with their gloved hand to the work station, then began to pick through the grapes with their gloved hands. On 05/09/24 at 9:13 a.m., Cook #1 stated they did not wash their hands between glove changes, and should have washed and changed their gloves after moving the trash can. On 05/09/24 at 9:18 a.m., the DM stated they were responsible to ensure all infection control practices were maintained in the kitchen. On 05/09/24 at 9:25 a.m., the administrator stated the DM was responsible to ensure the kitchen staff maintained infection control practices in the kitchen. The administrator stated they had not made observations of the kitchen to ensure the POC had been implemented.	{C 391}		

Delivery via email to: hre-ed@12oaks.net

June 20, 2024

License Number: AL7203

Ms. Lauren Luker, Administrator
Heatheridge Assisted Living
2130 South 85th East Avenue
Tulsa, OK 74129

RE: Survey Event 4NEJ13

Dear Ms. Luker:

On **May 9, 2024**, a Licensure inspection revisit was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 12, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/30/2024

Facility Name: Heatheridge Assisted Living

License Number: AL7203

Survey Event ID: 4NEJ13

Date Survey Completed: 5/9/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: This STANDARD is not met as evidenced by: {C 391} Based on observation and interview, the center failed to ensure food was stored and prepared in a sanitary manner.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Dietary Manager will be referred to as DM here after, or designee will keep a log of pre-prepared and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual. ED will inservice dietary staff over proper handwashing technique, proper way to wear a beard net, hair covering/hair net, and the proper way to store foods, labeling, and when to discard. DM or designee will check dry storage, walk in, and freezer for labled and dated foods, any variances found will be discarded immediately. DM or designee will sign off ensuring compliance daily. DM or designee will ensure all dietary staff are properly dressed each day with hairnet or hair covering with no loose hairs. DM or designee will ensure those with facial hair is kept back in a beard net at all times while in the kitchen. DM or designee will inservice dietary staff monthly on food storage, preperation, and service, weekly for thirty days, monthly for one quarter, and quarterly thereafter. ED or designee will periodically monitor meal times for food storage, preparation, and service, all variances will be documented on a separate form and reviewed monthly via QAPI. ED or designee will monitor storage log for compliance every day for thirty days as applicable, monthly for one quarter, and for one quarter there after, these will be reviewed quarterly through QAPI.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

DM or designee will keep a log of pre-prepared and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual. ED will inservice dietary staff over proper handwashing technique, proper way to wear a beard net, hair covering/hair net, and the proper way to store foods, labeling, and when to discard. DM or designee will check dry storage, walk in, and freezer for labled and dated foods, any variances found will be discarded immediately. DM or designee will sign off ensuring compliance daily. DM or designee will

	ensure all dietary staff are properly dressed each day with hairnet or hair covering with no loose hairs. DM or designee will ensure those with facial hair is kept back in a beard net at all times while in the kitchen. DM or designee will inservice dietary staff monthly on food storage, prperation, and service weekly for thirty days, monthly for one quarter, and quarterly thereafter. ED or designee will periodically monitor meal times for food storage, preparation, and service, all variances will be documented on a separate form and reviewed monthly via QAPI. ED or designee will monitor storage log for compliance every day for thirty days as applicable, monthly for one quarter, and for one quarter there after, these will be reviewed quarterly through QAPI.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	DM or designee will keep a log of pre-prepared and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual. ED will inservice dietary staff over proper handwashing technique, proper way to wear a beard net, hair covering/hair net, and the proper way to store foods, labeling, and when to discard. DM or designee will check dry storage, walk in, and freezer for labled and dated foods, any variances found will be discarded immediately. DM or designee will sign off ensuring compliance daily. DM or designee will ensure all dietary staff are properly dressed each day with hairnet or hair covering with no loose hairs. DM or designee will ensure those with facial hair is kept back in a beard net at all times while in the kitchen. DM or designee will inservice dietary staff monthly on food storage, prperation, and service weekly for thirty days, monthly for one quarter, and quarterly thereafter. ED or designee will periodically monitor meal times for food storage, preparation, and service, all variances will be documented on a separate form and reviewed monthly via QAPI. ED or designee will monitor storage log for compliance every day for thirty days as applicable, monthly for one quarter, and for one quarter there after, these will be reviewed quarterly through QAPI.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	DM or designee will keep a log of pre-prepared and stored foods daily as applicable to ensure storage compliance as accordianced by Chapter 257 Food Manual. ED will inservice dietary staff over proper handwashing technique, proper way to wear a beard net, hair covering/hair net, and the proper way to store foods, labeling, and when to discard. DM or designee will check dry storage, walk in, and freezer for labled and dated foods, any variances found will be discarded immediately. DM or designee will sign off ensuring compliance daily. DM or designee will

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OSDH Response: Element accepted	Yes	☐	No ☐
5. On what date will corrective action be completed?	6/12/2024		
OSDH Response: Element accepted	Yes	☐	No ☐
Administrator's Signature Lauren Paige Luker OAC 310:663-25-4(F)		Date 5/30/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

FINAL DETERMINATION NOTICE
USPS Tracking #7021 2720 0002 0354 1693

Delivery via email to: Paige Luker <hre-ed@12oaks.net>

June 28, 2024

License Number: AL7203

Ms. Lauren Paige Luker, Administrator
Heatheridge Assisted Living
2130 South 85th East Avenue
Tulsa, OK 74129

Survey Event ID: 4NEJ14

Dear Ms. Luker:

A revisit conducted **June 21, 2024**, revealed that your facility corrected deficiencies effective **June 12, 2024**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to 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

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure:

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/21/2024
NAME OF PROVIDER OR SUPPLIER HEATHERIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2130 SOUTH 85TH EAST AVENUE TULSA, OK 74129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS A revisit was conducted on 06/20/24 and 06/21/24. All deficiencies from the 02/05/24 survey were cleared. Census: 77	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE