OKLAHOMA
State Department
of Health

Delivery via email to: okcharbor@gmail.com

January 10, 2023

License Number: RC5521
Survey Event ID: C6OK11

Mr. Barry Gilliam, Jr., Administrator
Veterans Harbor
4100 North Newport Avenue
Oklahoma City, OK 73112

Dear Mr. Gilliam, Jr.:

Enclosed is a report of the complaint investigation conducted at your Residential Care facility on **January 6, 2023**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

Katie Stagner

Katie Stagner
Long Term Care Enforcement Analyst
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Veterans Harbor**
Address: **4100 North Newport Avenue**
City, State, Zip: **Oklahoma City, Oklahoma 73112**
Provider #: **RC5521**
Complaint #: **OK00059861**
Investigation Date(s): **January 5th – 6th, 2023**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to protect the residents from abuse.	**US**
2. The home failed to ensure the nutritional needs of the residents were met.	**US**
3. The home failed to maintain an effective pest control program so that the residents would be free of roaches and bedbugs.	**US**
4. The home failed to ensure the residents were clean and received assistance as needed with ADL's.	**US**

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

An unannounced on-site investigation was initiated on 01/05/2023 at 2:10 p.m.

A sample of three residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the home failing to protect residents from abuse was conducted.

Facility abuse policy was reviewed. Resident council minutes, greivances and incident reports were reviewed. Computerized system for tracking resident income and expenditures was reviewed for sampled residents.

Residents were observed to be treated with dignity and respect at all times. Residents were observed requesting and receiving funds from there accounts. No signs of abuse were observed.

Residents reported staff treated them with dignity and respect. They denied any concerns of money missing from their accounts. Staff stated they were trained to report to the administrator immediately any perception of mistreatment or abuse of a resident.

At the time of the investigation, there was no deficient practice related to the home protecting the residents from abuse.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the home failing to ensure the nutritional needs of the residents were met was conducted.

Weekly menus were reviewed. Quarterly reports from the registered dietitian were reviewed.

Meal service was observed. Portion sizes served exceeded what was listed on the menu. The refrigerator and freezer was observed to be well stocked. Afternoon snack was observed being set out for residents to partake of freely.

Residents reported no concerns with the food or the quantities of food served. They reported being able to request additional food if they wanted it. Dietary staff reported that residents could request seconds after all residents had been served.

At the time of the investigation, there was no deficient practice related to the home ensuring the nutritional needs of the residents were met.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the home failing to maintain an effective pest control program so that the residents would be free of roaches and bedbugs was conducted.

Documentation of quarterly pest control services were reviewed. Medication administration records were reviewed for any medical treatment for bed bug bites.

Observations were made in resident rooms, dining room, and common areas with no sightings of roaches nor bed bugs. No residents were observed with insect bites or itching. Electronic thermal equipment, used for bed bug extermination, was observed in back hallway.

Residents denied the presence of roaches or bed bugs in their rooms or common areas. The Administrator reported that electronic thermal equipment and powdered insecticide was used by facility maintenance staff for exterminating bed bugs if sighted at any time.

At the time of the investigation, there was no deficient practice related to the home maintaining an effective pest control program so that the residents would be free of roaches and bedbugs.

Allegation #4: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the home failing to ensure the residents were clean and received assistance as needed with ADL's was conducted.

Facility policy on provision of ADL care was reviewed. Clinical records were reviewed for assessments.

Residents were observed to be clean and dressed appropriately. Housekeeping staff were observed cleaning resident rooms and changing linens. No lingering odors were smelled in resident rooms nor in hallways.

Staff reported residents were required to bathe and change their clothes at least three times per week. Residents reported that staff reminded them to bathe and change their clothes if they noticed them wearing the same clothes more than two days. Housekeeping reported that all resident rooms and bathrooms were cleaned and their linens were changed at least twice a week.

At the time of the investigation, there was no deficient practice related to the home ensuring the residents were clean and received assistance as needed with ADL's.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1, #2, #3, and #4. No further action is required.

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

Thank you for bringing these concerns to our attention.

Ernestine Scovens

Ernestine Scovens RN, CHFS

Date report completed: 01/06/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC5521	A. BUILDING: _____ B. WING _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VETERANS HARBOR	4100 NORTH NEWPORT AVENUE OKLAHOMA CITY, OK 73112

(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
R 000	INITIAL COMMENTS A complaint investigation (#OK00059861) was conducted from 01/05/23 through 01/06/23. No deficiencies were cited.	R 000		

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