OKLAHOMA
State Department
of Health

Delivery via email to: bjgilliam@okcharbor.com; administration@okcharbor.com

August 28, 2024

License Number: RC5521
Survey Event ID: **YT1N11**

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

Dear Mr. Gilliam, Jr.:

Enclosed is the summary of deficiencies from the complaint investigation conducted at your Residential Care facility on **August 14, 2024**.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the spaces provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

- A statement of exactly how the facility has or intends to correct each deficiency.
- The method of correction. This includes who is responsible for the correction.
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- A reasonable date of correction, which will normally be within 30 days of this notice.

  NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **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 this completed form for your files.

In the event that we find your Plan of Correction unacceptable, you will be notified of the reason(s) it is not acceptable and we will request another Plan of Correction. If your plan of correction is acceptable, there will be no acknowledgement. We will conduct a revisit in accordance with your stated correction dates. If you have any questions concerning this letter, please contact me at (405) 426-8200.

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In accordance with O.S. 63 830.1, 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 833-RC). 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 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 calendar days 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 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, or telephone at (405) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
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INVESTIGATIVE REPORT

Facility: **Veterans Harbor**
Address: **4100 North Newport Avenue**
City, State, Zip: **OKC, OK 73112**
Provider #: **RC5521**
Complaint #: **OK00066209**
Investigation Date(s): **08/13/24 and 08/14/24**

ALLEGATION(S)
The home neglected to provide Oklahoma State Department of Health and Local law enforcement timely notification of a missing resident and failed to provide adequate supervision to prevent the elopement of dependent residents.
The home failed to ensure residents were appropriate for admission.

An unannounced on-site investigation was initiated 08/14/2024 at 8:20 a.m.

A sample of six residents, including any identified residents, 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 Summary of Complaint Investigation:

Observations were made of residents signing out and in on the sheets located near the medication room and kitchen entrance. Residents were observed clean and well groomed free of odors. No residents were observed. needing assistance with meals, grooming, hygiene, or toileting.

Residents were interviewed and asked about the process for leaving the facility. The residents were asked. About their ability to care for themselves and if they require assistance with care.

Staff were asked about the process for missing persons, and residents' ability to leave the facility. They were also asked about admission criteria and residents' ability to care for themselves.

Residents' admission packet, facility incident reports, facilities report to the Oklahoma State Department of health, medication documentation, nurses' notes, and policies were reviewed.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

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of Health

Date report completed: Click to Enter a Date

OKLAHOMA
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of Health

INVESTIGATIVE REPORT

Facility: **Veterans Harbor**
Address: **4100 North Newport Avenue**
City, State, Zip: **OKC, OK 73112**
Provider #: **RC5521**
Complaint #: **OK00066367**
Investigation Date(s): **08/13/24 and 08/14/24**

ALLEGATION(S)
The home failed to provide adequate supervision to prevent elopements.

An unannounced on-site investigation was initiated 08/14/2024 at 8:20 a.m.

A sample of six residents, including any identified residents, 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 Summary of Complaint Investigation:

Observations were made of residents signing out and in on the sheets located near the medication room and kitchen entrance.

Residents were interviewed and asked about the process for leaving the facility.

Staff were asked about the process for missing persons, and residents' ability to leave the facility.

Residents' admission packet, facility incident reports, facilities report to the Oklahoma State Department of health, medication documentation, nurses' notes, and policies were reviewed.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/15/2024

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 _____	C 08/14/2024

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 Complaint investigations (OK00066209 and OK00066367) were worked on 08/13/24 and 08/14/2024. Facility Census: 71	R 000		
R 224 SS=D	310:680-3-6 (d) RECORDS AND REPORTS (d) The Department shall be notified of all incidents pertaining to fire, storm damage, death other than natural, residents missing, or utilities failure for more than four (4) hours, and incidents that result in fractures, head injuries or require treatment at a hospital. Notice shall be made no later than the next working day. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report a missing resident by the next business day for one (#1) of two sampled sampled residents reviewed for reporting. The administrator identified two residents who had been missing from the facility since 06/01/24. Findings: The facility "Medication Pass Exceptions" report, dated 07/16/24 through 08/14/24, documented Resident #1 was out of the facility on 07/24/24	R 224		

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 _____	C 08/14/2024

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 224	Continued From page 1 through 08/14/24. A medication technician communication report, dated 07/25/24, documented Resident #1 was out of the facility. An ODH form 283 documented Resident #1 had walked away from the facility on 07/24/24 and had not returned or checked in. The fax transmittal confirmation sheet documented the report had been faxed to the Oklahoma State Department of Health on 07/29/24 at 12:31 p.m. The facility reported Resident #1 missing three business days after they had been missing. On 08/14/24 at 10:56 a.m., the social services director, stated Resident #1 was last seen by the medication administration technician on 07/24/24. They then stated "the last time the medications technician had seen her was on 07/24/24. I did not know the police were called on the 07/24/24. Reviewed the MED pass exceptions sheet and the social service director agreed that someone knew and the report should have been sent by the next business day no later then 07/24/2024. On 08/14/24 at 12:04 p.m., the administrator stated the ball was dropped and it should have been reported by the next business day.	R 224		

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Delivery via email to: bjgilliam@okcharbor.com; administration@okcharbor.com

September 11, 2024

License Number: RC5521
Survey Event ID: **YT1N11**

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

Dear Mr. Gilliam, Jr.:

On **August 14, 2024**, a complaint investigation was conducted at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 20, 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

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

Enclosure

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 _____	C 08/14/2024

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 Complaint investigations (OK00066209 and OK00066367) were worked on 08/13/24 and 08/14/2024. Facility Census: 71	R 000		
R 224 SS=D	310:680-3-6 (d) RECORDS AND REPORTS (d) The Department shall be notified of all incidents pertaining to fire, storm damage, death other than natural, residents missing, or utilities failure for more than four (4) hours, and incidents that result in fractures, head injuries or require treatment at a hospital. Notice shall be made no later than the next working day. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report a missing resident by the next business day for one (#1) of two sampled sampled residents reviewed for reporting. The administrator identified two residents who had been missing from the facility since 06/01/24. Findings:	R 224	The facility administrator instructed the office manager to conduct an in-service training with all direct care staff covering the use of the critical incident reports and the importance of their timely submission. If the incident occurs during non office hours, the staff will be instructed to text the administrator or office manager so that they can follow up and ensure it's timely submission. This will ensure that critical incidents will be reported in a time frame that meets the standard. This will be completed on or before September 20th, 2024. 9/10/24	

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Delivery via email to: bjgilliam@okcharbor.com; administration@okcharbor.com

November 13, 2024

License Number: RC5521
Survey Event ID: YT1N12

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

Dear Mr. Gilliam, Jr.:

On **November 13, 2024**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **August 14, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **September 20, 2024**.

If you have any questions concerning the information in this letter, please contact this office at (405) 426-8200.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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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 _____	R-C 11/13/2024

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 An offsite/paper revisit was conducted on 11/13/24. The facility was in substantial compliance.	{R 000}		

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