



Oklahoma State Department of Health
Creating a State of Health

September 27, 2019

License Number: AL5513

Ms. Debbie Evers, Administrator
Quail Creek Senior Living
12928 North May Avenue
Oklahoma City, OK 73120

RE: Survey Event ID: TZ7X11

Dear Ms. Evers:

On **September 3, 2019**, 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 September 3, 2019.

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;

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
Becky Payton (*Secretary*)

Jenny Alexopoulos, DO
Terry R Gerard II, DO
Charles W Grim, DDS, MHSA

R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

www.health.ok.gov
An equal opportunity
employer and provider



- (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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,



Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Quail Creek Senior Living
Address: 12928 North May Avenue
City, State, Zip: Oklahoma City,
Provider #: AL5513
Complaint #: OK00053901
Investigation Date(s): 08/27/19 through 08/29/19 and 09/03/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure proper administration of medications.	S

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

An unannounced on-site investigation was initiated on Tuesday, August 27, 2019 at 11:07 a.m.

A sample of 8 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1922 and C1923 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script, appearing to read "Billie Seeman", is written over a horizontal line.

Billie Seeman, RN Clinical Health Facility Surveyor

Date report completed: 09/05/2019

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Quail Creek Senior Living
Address: 12928 North May Avenue
City, State, Zip: Oklahoma City, 73120
Provider #: AL5513
Complaint #: OK00054077
Investigation Date(s): 08/27/19 through 08/29/19 and 09/03/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to treat residents with dignity and respect and failed to provide care according to the resident contracts.	US

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

An unannounced on-site investigation was initiated on Tuesday, August 27, 2019 at 11:07 a.m.

A sample of #3 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 related to verbal abuse by staff and neglecting to change incontinent residents and providing food to residents was conducted.

The residents were provided incontinent care and were assisted and reminded of meal time. No residents were observed to be afraid of the staff. The residents were well groomed and did not have odors. The residents were observed during rounds and one resident was observed to have a wet brief, pajama pants, and sheets. The staff stated the resident wet his clothes and sheets whenever he urinated.

The residents stated the staff had not yelled at them or hurt them. One resident stated the staff spoke to her rudely and she had not reported it to anyone. The residents stated the staff checked on them and they had a call pendant to call for assistance if they needed help. One resident stated she could not remember having a procedure or missing any meals.

The staff stated they checked on the residents who were incontinent every two-three hours and reminded residents and/or assisted residents to the dining room for meals. The administrator was made aware of the allegation of verbal abuse and immediately started an investigation. The administrator stated a meal was delivered to the resident's apartment who had a procedure and missed lunch and supper.

The staff back ground checks, abuse and neglect in-service, incident reports, resident records, communication logs were reviewed. The direct care staff had no previous abuse or neglect violations, no reports of abuse by the staff were documented. The communication log did not document "all residents had been left wet by the evening shift." One resident was documented to have been wet several times. (This resident was identified as getting his clothing, and bed linens wet each time he was incontinent of urine.)

At the time of the investigation, the residents were being provided incontinent care, reminded and assisted to meals and the report of verbal abuse was immediately investigated after being reported to the administrator.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. 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.



Billie Seeman, RN, Clinical Health Facility Surveyor

Date report completed: 09/06/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

12928 NORTH MAY AVENUE
OKLAHOMA CITY, OK 73120

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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 potential for more than minimal harm for all ** residents who received their nutrition from the kitchen. Findings: 310:257-5-31. In-use utensils, between-use storage During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: (5) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not Time/Temperature Control for Safety Food;... 310:257-5-60. Ready-to-eat, Time/Temperature Control for Safety Food, date marking. (d) A date marking system that meets the criteria stated in (a) and (b) of this Section may include: (3) Marking the date or day the original container is opened in a food service establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified in (b) of this Section;... 310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 310:257-7-84. Cooking and baking equipment (b) The cavities and door seals of microwaves ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. 310:257-9-70. Cleaning receptacles	C 391		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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 2 (b) Soiled receptacles and waste handling units for refuse, recyclables, and returnables shall be cleaned at a frequency necessary to prevent them from developing a buildup of soil or becoming attractants for insects and rodents. 310:257-11-41. Cleaning, frequency and restrictions (a) The physical facilities shall be cleaned as often as necessary to keep them clean. On 08/28/19 at 1:36 p.m., the following observations were made during a tour of the kitchen: Dispensing scoop in cheerios and flour container in dry storage; 1.25 pound bag of spinach not labeled with opened date; 2 quart container of nacho cheese dip not labeled with opened date; Three-quarters of an extra large watermelon, covered with aluminum foil not labeled with cut date or placed in a sealed container; One-half of a small watermelon covered with aluminum foil not labeled with cut date or placed in a sealed container; Splattered grease, dust, and food debris on a shelf under the grill; Food splattered, food crumbs, and food debris in microwave and food crumbs under the microwave; A trash/waste receptacle contained in a stand which was covered with dried food and dust; and A puddle of shiney material on the floor between the deep fat fryer and the grill and an open area of floor by the oven covered with a metal grate contained trash, leaves, bread ties, paper, and food debris.	C 391		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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 3 The dining room supervisor stated the scoop in the cheerios must have been left over from breakfast and she had told the dietary employees to never leave scoops in anything. She stated the refrigerated food items should have had the date they were opened on them and the watermelons should have been cut into smaller pieces and placed in appropriate containers. The microwave had splattered, dried food and food debris on the inside of the unit and food debris and crumbs under it. The dining room supervisor stated the trash/waste receptacle stand had obvious dried food and dust on it and it was supposed to be cleaned at least once a month and as needed. She stated splattered grease, food crumbs, and food debris were on the shelf under the grill. She identified the shiney material on the floor between the deep fat fryer and the grill as a puddle of grease. The dining room supervisor stated the grate covered open floor area by the oven was a catch all for all kinds of trash and debris, especially when the back door was opened. The grate was supposed to be taken off and the area cleaned before it had gotten that bad.	C 391		
C 532 SS=E	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status;	C 532		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120
--	--

(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 532	Continued From page 4 (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure all required components were included in the comprehensive assessment for 5 (#3, 5, 6, through #8) of 8 sampled residents who had completed comprehensive assessments. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #5 Resident #5 had a documented admission date of 05/29/15. An annual assessment, dated 05/29/19, did not include history of infections and prior medical history, list of current medications, weight or weight changes, and special treatments and procedures. On 09/03/19 at 2:21 p.m., the registered nurse (RN) stated she did not know why the assessment had not had all of the required components completed. RESIDENT #7 Resident #7 had a documented admission date of 05/31/19. A significant change assessment, dated 07/02/19, did not include a list of current	C 532		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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 532	Continued From page 5 medications, mental health history, diet order, height, weight, or weight changes, history of mood disorder, history of abnormal behaviors, and sensory and physical impairments. On 09/03/19 at 2:21 p.m., the RN stated she had completed the assessment for another nurse. She also stated she was more concerned with the care the residents had received and not the completion of paper work. Resident #3, 6 and #8's comprehensive assessments did not document the residents current medications. On 09/03/19 at 2:21 p.m., the registered nurse stated she did not know she had to attach the medication list to the assessment.	C 532		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the	C 543		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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 543	Continued From page 6 resident's representative and the person completing the assessment form for 4 (#5 through #8) of 8 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #5 Resident #5 moved into the center on 05/29/15 with diagnoses that included dementia, right hip pain, and osteoporosis. Her most current annual assessment, dated 05/29/19, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 09/03/19 at 2:21 p.m., the registered nurse (RN) stated the resident was capable of signing the assessment and she should have signed the assessment at the time it was completed. RESIDENT #7 Resident #7 moved into the center on 05/31/19 with diagnoses that included Parkinson's disease, hypertension, and chronic kidney disease. Her most current assessment, a significant change assessment, dated 07/02/19, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 09/03/19 at 2:21 p.m., the RN stated the resident's husband had been present during the assessment and the resident or her husband should have signed the assessment at the time it was completed.	C 543			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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 543	Continued From page 7 Resident #6 and #8 's current comprehensive assessment did not document signatures to indicate a personal interview had been conducted at the time of the assessment. On 09/03/19 at 2:54 p.m., the registered nurse stated the resident and or resident representative had not signed the assessment.	C 543		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure water temperatures did not exceed 115 degrees Fahrenheit (F) in the residents' rooms for 10 (#1, 2, 4, 5, and 7 through #12) of 10 sampled residents. This deficient practice had the potential for more than minimal harm at a pattern. Findings: On 08/29/19 at 12:25 p.m., resident #2's bathroom hot water measured 121.5 degrees F.	C 701		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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 701	Continued From page 8 On 09/03/19 at 9:41 a.m. through 10:02 a.m., the following bathroom hot water temperatures were obtained in the memory care unit: Resident #1 120.0 degrees F; Resident #9 118.2 degrees F; Resident #10 121.1 degrees F; Resident #11 123.0 degrees F; and Resident #12 123.2 degrees F. At 10:06 a.m. through 10:13 a.m., the following bathroom hot water temperatures were obtained with the maintenance director: Resident #2 - 115.7 degrees F Maintenance director - 108.5 degrees F; Resident #10 - 117.0 degrees F Maintenance director - 110.0 degrees F; Resident #11 - 116.7 degrees F Maintenance director - 109.5 degrees F; and Resident #12 - 116.2 degrees F Maintenance director - 107.5 degrees F. The maintenance director stated he thought the state (OSDH) required hot water temperatures to be 120.0 degrees F. He stated the hot water mixer started at 140.0 degrees F and after it was mixed it was between 115.0 degrees F and 120.0 degrees F in the rooms. At 10:43 a.m., resident #5's assisted living bathroom hot water measured 121.5 degrees F. At 1:44 p.m., resident #1's bathroom hot water measured 118.2 degrees F. Certified medication aide/employee #7 stated resident #1 was able to use the restroom independently. He stated at times she required reminders to use the restroom.	C 701		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

QUAIL CREEK SENIOR LIVING

**12928 NORTH MAY AVENUE
OKLAHOMA CITY, OK 73120**

(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 701	Continued From page 9 At 2:58 p.m., resident #7's assisted living bathroom hot water measured 123.3 degrees F.	C 701		
C1120 SS=E	310:663-11-2 QUALITY ASSURANCE REPRESENTATIVES The quality assurance committee shall include at least the following: (1) registered nurse or physician if a medical problem is to be monitored or investigated; (2) assisted living center administrator; (3) direct care staff person or a staff person who has responsibility for administration of medications; and (4) pharmacist consultant if a medication problem is to be monitored or investigated. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to have a direct care staff member attend the quality assurance (QA) meetings. This failed practice had the potential for more than minimal harm at a pattern. Findings: The QA meetings were reviewed. Three of the four QA meetings did not have a direct care staff member or a staff member responsible for administering medications in attendance. On 08/28/19 at 4:45 p.m., the registered nurse stated there was not a direct care staff member or a staff member who was responsible for administering medication in attendance of the QA meetings.	C1120		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING. _____	(X3) DATE SURVEY COMPLETED 09/03/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

QUAIL CREEK SENIOR LIVING

**12928 NORTH MAY AVENUE
OKLAHOMA CITY, OK 73120**

(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
C1505	Continued From page 10	C1505		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to obtain laboratory tests as ordered by the physician for 1 (#8) of 2 sampled residents who had orders for laboratory tests. Findings: Resident #8 had a diagnosis of diabetes with an order for a hemoglobin A1c (A laboratory test to determine average blood sugar levels over the past 2-3 months.) to be drawn every 3 months.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

QUAIL CREEK SENIOR LIVING

**12928 NORTH MAY AVENUE
OKLAHOMA CITY, OK 73120**

(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
C1505	Continued From page 11 The residents record documented the lab test was drawn on 01/18/18, 03/20/18, 09/17/18, 02/25/19 and 08/21/19. The lab test was not obtained every three months as ordered by the physician. On 09/03/19 at 3:30 p.m., the registered nurse stated she did not have any other hemoglobin A1c lab test results for resident #8.	C1505		
C1922 SS=D	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center's staff failed to observed the swallowing of medication for 1 (#1) of 8 sampled residents who were administered medication by the staff. This failed practice had the isolated potential for more than minimal harm. Findings: Resident #1 had diagnosis of dementia, hypertension, and anxiety disorder. On 08/27/19 at 1:47 p.m., the resident's family member stated she had found medications in a plastic cup left in resident #1's apartment several times. She stated on one occasion the medication cup was labeled with another residents name. She stated she reported it to the	C1922		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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
C1922	Continued From page 12 executive director and was not sure if anything had been done. On 09/03/19 at 3:48 p.m., the executive director stated a family member found a medication cup labeled with resident #3's name in resident #1's apartment. She stated the medication cup was left in resident #1's apartment by certified medication aide/employee #9 who did not watch the resident swallow the medication. The center's policy, titled Preparation for Medication Administration, dated as revised 09/01/12, documented, "...The resident is always observed after administration to ensure that the dose was completely ingested..."	C1922		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports.	C1923		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B WING _____	(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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
C1923	Continued From page 13 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a medication incident/error report was documented for 1 (#3) of 8 sampled residents who were administered medication by the center. This failed practice had the isolated potential for more than minimal harm. Findings: On 09/03/19 at 3:48 p.m., the executive director stated a medication cup labeled with resident #3's name was found in resident #1's apartment. She stated the licensed practical nurse, who was no longer employed at the center handled the situation. She stated she did not have documentation of the incident or a medication error report and was not sure if resident #3 was administered the correct medication. At 5:01 p.m., resident #3 stated she would not know if she received the wrong medications because the staff put the medication in a cup for her and she did not know what she was taking. She stated she knew who the licensed practical nurse used to be and he did not speak with her about possibly getting the wrong medications. No documentation was provided of an incident report, investigation of the incident, or inservice/interventions put in place to prevent the incident from happening again.	C1923		
C5015 SS=D	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with	C5015		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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	
C5015	Continued From page 14 the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident;	C5015			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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
C5015	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a written plan of accommodation was signed, as required, by the resident or the resident's responsible party and the resident's physician for 1 (#7) of 1 sampled resident. This deficient practice resulted in the isolated potential for more than minimal harm. Findings: RESIDENT #7 Resident #7 was admitted into the center on 05/31/19 with diagnoses that included Parkinson's disease, hypertension, and chronic kidney disease. Her most current assessment, a significant change assessment, dated 07/02/19, documented she was oriented to person and place, confused at times, and forgetful. She was chairfast, non-weight bearing, and used a wheelchair for mobility. She required one person assistance to bathe, ambulate, and eat, and two person assistance with dressing, transfers, and toileting. On 09/03/19 at 1:29 p.m., a plan of accommodation provided for resident #7 had not contained a signature of the resident, the resident's representative, or the resident's physician. At 2:21 p.m., the registered nurse stated she did not know why resident #7's plan of accommodation was not signed by the resident, their representative, or their physician.	C5015		

STATE WORKLOAD REPORT

Provider/Supplier Number AL5513	Provider/Supplier Name QUAIL CREEK SENIOR LIVING
------------------------------------	---

Type of Survey (select all that apply)

2	3			
---	---	--	--	--

- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
---	--	--	--	--

- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. <i>BS</i> 36191	08/27/2019	09/03/2019	1.50	1.00	25.00	0.00	9.25	8.00
2. <i>BS</i> 35195	08/27/2019	09/03/2019	0.50	0.00	20.50	0.00	6.75	6.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....	0.00	Total RO Supervisory Review Hours....	0.00
--	------	---------------------------------------	------

Total SA Clerical/Data Entry Hours....	0.00	Total RO Clerical/Data Entry Hours.....	0.00
--	------	---	------

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

SEP 30 2019 *jm*



Oklahoma State Department of Health
Creating a State of Health

October 10, 2019

License Number: AL5513

Ms. Debbie Evers, Administrator
Quail Creek Senior Living
12928 North May Avenue
Oklahoma City, OK 73120

RE: Survey Event TZ7X11

Dear Ms. Evers:

On September 3, 2019, 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 **November 10, 2019**.

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) 271-6868.

Sincerely,

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

LC/KS

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
Becky Payton (*Secretary*)

Jenny Alexopoulos, DO
Terry R Gerard II, DO
Charles W Grim, DDS, MHSA

R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

www.health.ok.gov
An equal opportunity
employer and provider



{X6} DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

QUAIL CREEK SENIOR LIVING

12928 NORTH MAY AVENUE
OKLAHOMA CITY, OK 73120

(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 potential for more than minimal harm for all ** residents who received their nutrition from the kitchen. Findings: 310:257-5-31. In-use utensils, between-use storage During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: (5) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not Time/Temperature Control for Safety Food;... 310:257-5-60. Ready-to-eat, Time/Temperature Control for Safety Food, date marking. (d) A date marking system that meets the criteria stated in (a) and (b) of this Section may include: (3) Marking the date or day the original container is opened in a food service establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified in (b) of this Section;... 310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 310:257-7-84. Cooking and baking equipment (b) The cavities and door seals of microwaves ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. 310:257-9-70. Cleaning receptacles	C 391	Refer to POC Template survey event ID#TZ7X11 ID Prefix tag C391 Refer to POC Template survey event ID#TZ7X11 ID Prefix tag C391 Refer to POC Template survey event ID#TZ7X11 ID Prefix tag C391 Refer to POC Template survey event ID#TZ7X11 ID Prefix tag C391	11/10/19 11/10/19 11/10/19

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120			
(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)		(X6) COMPLETE DATE
C 391	Continued From page 2 (b) Soiled receptacles and waste handling units for refuse, recyclables, and returnables shall be cleaned at a frequency necessary to prevent them from developing a buildup of soil or becoming attractants for insects and rodents. 310:257-11-41. Cleaning, frequency and restrictions (a) The physical facilities shall be cleaned as often as necessary to keep them clean. On 08/28/19 at 1:36 p.m., the following observations were made during a tour of the kitchen: Dispensing scoop in cheerios and flour container in dry storage; 1.25 pound bag of spinach not labeled with opened date; 2 quart container of nacho cheese dip not labeled with opened date; Three-quarters of an extra large watermelon, covered with aluminum foil not labeled with cut date or placed in a sealed container; One-half of a small watermelon covered with aluminum foil not labeled with cut date or placed in a sealed container; Splattered grease, dust, and food debris on a shelf under the grill; Food splattered, food crumbs, and food debris in microwave and food crumbs under the microwave; A trash/waste receptacle contained in a stand which was covered with dried food and dust; and A puddle of shiny material on the floor between the deep fat fryer and the grill and an open area of floor by the oven covered with a metal grate contained trash, leaves, bread ties, paper, and food debris.	C 391	Refer to POC Template survey event ID# T27X11 ID Prefix tag C391 Refer to POC Template survey event ID# T27X11 ID Prefix tag C391		11/10/19 11/10/19

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120			
(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 3 The dining room supervisor stated the scoop in the cheerios must have been left over from breakfast and she had told the dietary employees to never leave scoops in anything. She stated the refrigerated food items should have had the date they were opened on them and the watermelons should have been cut into smaller pieces and placed in appropriate containers. The microwave had splattered, dried food and food debris on the inside of the unit and food debris and crumbs under it. The dining room supervisor stated the trash/waste receptacle stand had obvious dried food and dust on it and it was supposed to be cleaned at least once a month and as needed. She stated splattered grease, food crumbs, and food debris were on the shelf under the grill. She identified the shiny material on the floor between the deep fat fryer and the grill as a puddle of grease. The dining room supervisor stated the grate covered open floor area by the oven was a catch all for all kinds of trash and debris, especially when the back door was opened. The grate was supposed to be taken off and the area cleaned before it had gotten that bad.	C 391	Refer to POC Template survey event ID #TZ7X11 ID Prefix tag C391	11/10/19	
C 532 SS=E	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status;	C 532	Refer to POC Template survey event ID #TZ7X11 ID Prefix tag C532	11/10/19	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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)	(X6) COMPLETE DATE
C 532	Continued From page 4 (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure all required components were included in the comprehensive assessment for 5 (#3, 5, 6, through #8) of 8 sampled residents who had completed comprehensive assessments. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #5 Resident #5 had a documented admission date of 05/29/15. An annual assessment, dated 05/29/19, did not include history of infections and prior medical history, list of current medications, weight or weight changes, and special treatments and procedures. On 09/03/19 at 2:21 p.m., the registered nurse (RN) stated she did not know why the assessment had not had all of the required components completed. RESIDENT #7 Resident #7 had a documented admission date of 05/31/19. A significant change assessment, dated 07/02/19, did not include a list of current	C 532	Refer to POCTemplate Survey ID# T27X11 ID Prefix tag C532	11/10/19

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120			
(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 532	Continued From page 5. medications, mental health history, diet order, height, weight, or weight changes, history of mood disorder, history of abnormal behaviors, and sensory and physical impairments. On 09/03/19 at 2:21 p.m., the RN stated she had completed the assessment for another nurse. She also stated she was more concerned with the care the residents had received and not the completion of paper work. Resident #3, 6 and #8's comprehensive assessments did not document the residents current medications. On 09/03/19 at 2:21 p.m., the registered nurse stated she did not know she had to attach the medication list to the assessment.	C 532	Refer to POC Template survey event ID# TZ7X11 ID Prefix tag C532	11/10/19	
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the	C 543	Refer to POC Template survey event ID# TZ7X11 ID Prefix tag C532	11/10/19	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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 543	Continued From page 6 resident's representative and the person completing the assessment form for 4 (#5 through #8) of 8 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #5 Resident #5 moved into the center on 05/29/15 with diagnoses that included dementia, right hip pain, and osteoporosis. Her most current annual assessment, dated 05/29/19, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 09/03/19 at 2:21 p.m., the registered nurse (RN) stated the resident was capable of signing the assessment and she should have signed the assessment at the time it was completed. RESIDENT #7 Resident #7 moved into the center on 05/31/19 with diagnoses that included Parkinson's disease, hypertension, and chronic kidney disease. Her most current assessment, a significant change assessment, dated 07/02/19, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 09/03/19 at 2:21 p.m., the RN stated the resident's husband had been present during the assessment and the resident or her husband should have signed the assessment at the time it was completed.	C 543	Refer to POCTemplate survey event ID#TZ7X11 ID Prefix tag C543	11/10/19

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120			
(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)	(X6) COMPLETE DATE	
C 543	Continued From page 7 Resident #6 and #8 's current comprehensive assessment did not document signatures to indicate a personal interview had been conducted at the time of the assessment. On 09/03/19 at 2:54 p.m., the registered nurse stated the resident and or resident representative had not signed the assessment.	C 543	Refer to POC Template Survey event ID#TZ7X11 ID Prefix tag C543	11/10/19	
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure water temperatures did not exceed 115 degrees Fahrenheit (F) in the residents' rooms for 10 (#1, 2, 4, 5, and 7 through #12) of 10 sampled residents. This deficient practice had the potential for more than minimal harm at a pattern. Findings: On 08/29/19 at 12:25 p.m., resident #2's bathroom hot water measured 121.5 degrees F.	C 701	Refer to POC Template Survey event ID#TZ7X11 ID Prefix tag C701	11/10/19	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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 701	Continued From page 8 On 09/03/19 at 9:41 a.m. through 10:02 a.m., the following bathroom hot water temperatures were obtained in the memory care unit: Resident #1 120.0 degrees F; Resident #9 118.2 degrees F; Resident #10 121.1 degrees F; Resident #11 123.0 degrees F; and Resident #12 123.2 degrees F. At 10:06 a.m. through 10:13 a.m., the following bathroom hot water temperatures were obtained with the maintenance director: Resident #2 - 115.7 degrees F Maintenance director - 108.5 degrees F; Resident #10 - 117.0 degrees F Maintenance director - 110.0 degrees F; Resident #11 - 116.7 degrees F Maintenance director - 109.5 degrees F; and Resident #12 - 116.2 degrees F Maintenance director - 107.5 degrees F. The maintenance director stated he thought the state (OSDH) required hot water temperatures to be 120.0 degrees F. He stated the hot water mixer started at 140.0 degrees F and after it was mixed it was between 115.0 degrees F and 120.0 degrees F in the rooms. At 10:43 a.m., resident #5's assisted living bathroom hot water measured 121.5 degrees F. At 1:44 p.m., resident #1's bathroom hot water measured 118.2 degrees F. Certified medication aide/employee #7 stated resident #1 was able to use the restroom independently. He stated at times she required reminders to use the restroom.	C 701	Refer to PDC Template survey event ID# T27X11 ID Prefix tag C701	11/10/19

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120			
(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 701	Continued From page 9 At 2:58 p.m., resident #7's assisted living bathroom hot water measured 123.3 degrees F.	C 701	Refer to POC template survey event ID# TZ7X11	11/10/19	
C1120 SS=E	310:663-11-2 QUALITY ASSURANCE REPRESENTATIVES The quality assurance committee shall include at least the following: (1) registered nurse or physician if a medical problem is to be monitored or investigated; (2) assisted living center administrator; (3) direct care staff person or a staff person who has responsibility for administration of medications; and (4) pharmacist consultant if a medication problem is to be monitored or investigated. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to have a direct care staff member attend the quality assurance (QA) meetings. This failed practice had the potential for more than minimal harm at a pattern. Findings: The QA meetings were reviewed. Three of the four QA meetings did not have a direct care staff member or a staff member responsible for administering medications in attendance. On 08/28/19 at 4:45 p.m., the registered nurse stated there was not a direct care staff member or a staff member who was responsible for administering medication in attendance of the QA meetings.	C1120	Refer to POC template survey event ID# TZ7X11 ID Prefix tag C1120	11/10/19	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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
C1505	Continued From page 10	C1505	Refer to POC Template survey event ID# T27X11 ID Prefix tag C1505 Refer to POC Template survey event ID# T27X11 ID Prefix tag C1505	11/10/19 11/10/19
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to obtain laboratory tests as ordered by the physician for 1 (#8) of 2 sampled residents who had orders for laboratory tests. Findings: Resident #8 had a diagnosis of diabetes with an order for a hemoglobin A1c (A laboratory test to determine average blood sugar levels over the past 2-3 months.) to be drawn every 3 months.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120			
(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	
C1505	Continued From page 11 The residents record documented the lab test was drawn on 01/18/18, 03/20/18, 09/17/18, 02/25/19 and 08/21/19. The lab test was not obtained every three months as ordered by the physician. On 09/03/19 at 3:30 p.m., the registered nurse stated she did not have any other hemoglobin A1c lab test results for resident #8.	C1505	Refer to POC Template survey event ID# TZTX11 ID Prefix tag C1505	11/10/19	
C1922 SS=D	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center's staff failed to observed the swallowing of medication for 1 (#1) of 8 sampled residents who were administered medication by the staff. This failed practice had the isolated potential for more than minimal harm. Findings: Resident #1 had diagnosis of dementia, hypertension, and anxiety disorder. On 08/27/19 at 1:47 p.m., the resident's family member stated she had found medications in a plastic cup left in resident #1's apartment several times. She stated on one occasion the medication cup was labeled with another residents name. She stated she reported it to the	C1922	Refer to POC Template survey event ID# TZTX11 ID Prefix tag C1922	11/10/19	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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
C1922	Continued From page 12 executive director and was not sure if anything had been done. On 09/03/19 at 3:48 p.m., the executive director stated a family member found a medication cup labeled with resident #3's name in resident #1's apartment. She stated the medication cup was left in resident #1's apartment by certified medication aide/employee #9 who did not watch the resident swallow the medication. The center's policy, titled Preparation for Medication Administration, dated as revised 09/01/12, documented, "...The resident is always observed after administration to ensure that the dose was completely ingested..."	C1922	Refer to POC Template Survey event ID# T27X11 ID Prefix tag C1922	11/10/19
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports.	C1923	Refer to POC Template Survey event ID# T27X11 ID Prefix tag C1923	11/10/19

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

QUAIL CREEK SENIOR LIVING

12928 NORTH MAY AVENUE

OKLAHOMA CITY, OK 73120

(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
C1923	Continued From page 13 This Rule Is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a medication incident/error report was documented for 1 (#3) of 8 sampled residents who were administered medication by the center. This failed practice had the isolated potential for more than minimal harm. Findings: On 09/03/19 at 3:48 p.m., the executive director stated a medication cup labeled with resident #3's name was found in resident #1's apartment. She stated the licensed practical nurse, who was no longer employed at the center handled the situation. She stated she did not have documentation of the incident or a medication error report and was not sure if resident #3 was administered the correct medication. At 5:01 p.m., resident #3 stated she would not know if she received the wrong medications because the staff put the medication in a cup for her and she did not know what she was taking. She stated she knew who the licensed practical nurse used to be and he did not speak with her about possibly getting the wrong medications. No documentation was provided of an incident report, investigation of the incident, or inservice/interventions put in place to prevent the incident from happening again.	C1923	Refer to POC Template survey event ID#TZ7X11 ID Prefix tag C1923	11/10/19
C6015 SS=D	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with	C5015	Refer to POC Template survey event ID#TZ7X11 ID Prefix tag C5015	11/10/19

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2019
NAME OF PROVIDER OR SUPPLIER QUAIL CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
(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)	(X6) COMPLETE DATE
C5015	Continued From page 14 the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident;	C5015	Refer to POC Template survey event ID# T27X11 ID Prefix tag C5015	11/19/19