OKLAHOMA
State Department
of Health

Delivery via email to: jtownsend@proveersl.com

February 22, 2022

License Number: AL5513

Ms. Jillian Townsend, Administrator
Proveer at Quail Creek
12928 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: NJT211

Dear Ms. Townsend:

On **January 27, 2022**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

(1) Address how corrective action will be accomplished for affected residents;

(2) Address how other residents with the potential to be affected will be identified;

(3) Address measures or systemic changes to ensure the deficiency will not recur;

(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

(5) Include dates when corrective action will be completed for each violation; and
(6) Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.02.22 16:17:19 -06'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility:	**Proveer at Quail Creek**
Address:	**12928 North May Avenue**
City, State, Zip:	**Oklahoma City, Oklahoma 73120**
Provider #:	**AL5513**
Complaint #:	**OK00058308**
Investigation Date(s):	**January 24th, 25th, 26th and 27th, 2022**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to protect residents from sexual abuse.	S

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

An unannounced on-site investigation was initiated 01/24/2022 at 1:00 p.m.

A sample of 4 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 Centers for Medicare and Medicaid Services (CMS) 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, C1512 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation One. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Mary Cooper RN Digitally signed by Mary Cooper RN
Date: 2022.01.28 12:05:07 -06'00'

Mary Cooper RN/CHFS

Date report completed: 01/28/2022

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
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C 000	INITIAL COMMENTS A complaint investigation (#OK00058308) was conducted on 01/24, 01/25, 01/26, and 01/27/2022. The following abbreviations may have been used in this report. apt.=apartment CNA=Certified Nursing Assistant ED=Executive Director LPN=Licensed Practical Nurse	C 000		
C 711 SS=E	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on observation and interview the center failed to ensure emergency exit doors were not padlocked shut to prevent an emergency exit. This had the potential to affect 21 of 21 residents who resided in the memory care unit. LPN #1 identified 21 residents who resided in the	C 711		

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C 711	Continued From page 1 memory care unit. Findings: On 01/25/22 at 9:03 a.m., during observation in the memory care unit. Two emergency exit doors, on north and south halls were observed to have padlocks on the doors. At 9:52 a.m., housekeeper #1 was asked where the south emergency door exited to. She was not sure. She was asked who has the keys to the padlock. She stated, "Only maintenance does." At 9:56 a.m., maintenance #1 was asked to observe the north emergency exit door. He was asked where it exits to. He stated, "It exits to the yard...outside to the street through the hall to another secured door." He was asked why the door was padlocked. He stated, "We have runners." The emergency exit door was observed to have a padlock in place. Maintenance #1 unlocked the padlock and used the keypad to open the door. The interior door exited to a hallway with a stair case. The exterior emergency door exited outside to the parking lot area. Maintenance #1 stated, "The fire marshall told us to remove it, he came last week sometime."	C 711		
C1512 SS=J	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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	C1512		

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C1512	Continued From page 2 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or	C1512		

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C1512	Continued From page 3 c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 01/25/22 at 4:48 p.m., the Oklahoma State Department of Health (OSDH) confirmed the existence of an immediate jeopardy related to the center's failure to protect residents from sexual abuse. The center failed to assess the two residents involved and update care plan interventions; and failed to assess if other residents were at risk for sexual abuse. Additionally, the center failed to educate staff to identify, prevent and report sexual abuse. On 12/28/21 and 12/29/21 two residents who are cognitively impaired were observed by staff to be engaged in sexual activity. At 4:52 p.m., the Executive Director was informed of the existence of the immediate jeopardy. A request was made for an acceptable plan to remove the immediacy. On 01/26/22 at 4:55 p.m., the plan of removal was accepted by the Oklahoma State Department of Health. The plan of removal was as follows: "...Plan of Removal 01/25/2022 For this plan of removal, we will put the following actions into place: Assess all residents in memory care for wandering behavior and for sexual behaviors. We	C1512		

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C1512	Continued From page 4	C1512		

will have this done by 5 pm on 01/26/22.
Create a form and monitor hourly on form each resident identified to have wandering and /or sexual behaviors to identify location and if redirected. We will have this done by 5 pm on 01/26/22.
Create and implement an hourly tracking form for each resident door and shower room to ensure each door is locked We will have this done by 5 pm on 01/26/22.
Create a clear, concise, detailed policy and procedure on identifying and reporting resident sexual abuse and in-service all staff regarding new policies and procedures by 5 pm on 01/26/22.
All above detailed interventions to be documented on all care plans for all memory care residents identified at risk for victimization by 5 pm on 01/26/22..."

On 01/27/22, interviews were conducted with nursing staff regarding education and in-service information pertaining to the immediate jeopardy plan of removal. The staff stated they had been in-serviced and were able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal. Facility provided documentation resident assessments and care plan updates had been completed. Hourly door lock forms were observed on doors in the memory care unit.

On 01/27/22 at 2:55 p.m., the immediacy was lifted when all components of the plan of removal had been completed. The deficiency remained at an isolated event at a level of actual harm.

Based on observation, interview, and record review the center failed to protect residents from further abuse, implement interventions and train

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C1512	Continued From page 5 staff on how to identify, prevent and report sexual abuse for two (#1 and #2) of four residents sampled for abuse. The LPN identified 21 residents who resided in the memory care unit. Findings: An undated policy and procedure, titled, "Prevention of Physical/Sexual Abuse read in part, " ...Policy: It is the policy of [no center name on document] to provide a safe, abuse free, drug free environment for our residents and associates. Procedure: ...5. Any questionable incidents of physical or sexual abuse are reported immediately, investigated thoroughly, and followed up on ..." Resident (Res #1) had diagnoses which included, major depressive disorder, and other symptoms and signs involving cognitive function and awareness. A preadmission assessment, dated 12/23/2021, documented Res #1 was alert and oriented to person only, confused and forgetful and had poor judgement. A thirty day assessment, dated 01/16/2022, read in part, "...Healthcare Information Section...[Res #1] constantly roams and wanders into other's rooms and occasionally exit seeks. He requires redirection occasionally...Orientation/Memory/Cognitive Function ...Judgement and memory care are not always good. May occasionally put self at risk and rarely impact the life and well being of others. Needs monitoring and guidance and occasional redirection ..."	C1512		

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Resident (Res #2) had diagnoses which included, generalized anxiety disorder, and unspecified dementia without behavioral disturbance.

A preadmission assessment, dated 04/28/21 documented Res #2 was oriented to person and place, confused at times and had fair judgement.

"Evaluation and Service Plan" dated 10/23/2021, read in part "...Orientation Frequent: Requires frequent redirection and validation from staff. Behavior Resident does not need redirection due to behavior or emotions..."

After the incident on 12/28/21 and 12/29/21, there were no additional interventions put in place to prevent and protect all residents from further sexual abuse.

An "Oklahoma State Department of Health Incident Report Form," dated 12/28/2021, read in part "...I [Executive Director], received a phone call around 7:00pm on 12/29/21 from [Res #1's family member]. The [family member] stated he had been to the facility earlier that afternoon to visit [Res #1] at which time [Res #1] allegedly told [family member] that he 'had sex' with another male memory care resident..."

A "Nurse Progress Notes", dated 12/30/21 and attached to the incident report, read in part, "On 12/25/21 [Res #1] was roaming into different rooms and "checking on everyone." When [Res #1] went into [Res #2's]room, [Res #2] became very upset and was yelling " This isn't your room."...[Res #2] was very nervous and stated he didn't want anyone in his room. Staff locked [Res #2's] door...There were no other interactions with these residents the remainder of the weekend."

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C1512	Continued From page 7 CNA #2's written statements, attached to the incident report, read in part, "...[untimed] 12/28 Resident [Res #1] was standing outside of apt. [Res #2], the door was cracked. Res #2 was on his knees. Care staff intervened + [Res #1] was removed. 12/29 [Res#1] observed going into apt. [Res #2]. Upon entering, [Res #1] was observed fully clothed, while [Res #2] was kneeling in front of him. [Res #1] went to bathroom, to zip up pants. Care staff removed him from the apt ..." CNA #1's written statement, dated 12/29/21 and attached to the incident report, read in part, "...[untimed] On Wednesday December 29th 2021, CNA #2 ....informed me [Res #1] has gone into [Res #2's] apartment. I immediately went in and saw he had taken his shirt off so I asked him why his shirt was off and he told me "he wanted to go to bed." I explained to him that was not his apartment and asked him to come with me so I will show his room. He immediately put on his shirt and we both went out. This was after breakfast in the morning. I then reported what I saw to the head Aide..." Staff #1's written statement, dated 12/29/21 and attached to the incident report, read in part, " ...December 29, 2021 Sometime during breakfast, CNA #1 asked me to check on [Res #1] and [Res #2]. Because [Res #1] had went into [Res #2's] room. I walked in and saw [Res #2] sitting in his folded up chair. While [Res #1] stood in front of him with his pants down to his ankles. [Res#2] was performing oral sex on [Res #1]. Instantly I instructed them to stop and walked [Res #1] out of [Res #2's] room. Then immediately notified my nurse and administrator. Signed and dated 12/30/21."	C1512		

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C1512	Continued From page 8	C1512		

CNA #3's written statement, dated 12/30/21 and attached to the incident report, read in part, "[untimed] ...12/30/2021 I [CNA#3] on 12/29/2021 was informed [Res #1] was in [Res #2's] room as I unlocked the door [Res #1] was standing with hard on. He turned zip up pants. [Res #2] was sitting on the bed. Keep [Res #1] in sight after bringing him out room. Later on notice [Res #2] at his door then door closed. [Res #1] still in sight. Later on [Res #1] was out of sight, [Res #2's] door open + closed. I unlocked door, [Res #1] pants unzipped, [Res #2] was standing in room ...I asked what he was doing in room. He replied, I'm sorry. I informed him he is to not B [sic] in this room. His room down hall. I asked [Res #2] what was they doing. He looks; I ask what is going on here. He replied having sex ."

On 01/24/22 at 1:17 p.m., Res #1 was observed with a female resident. in the female residents room. Both residents were standing looking out the window.

At 2:10 p.m., Res #1 was wandering the hallway with another resident. Res #1 opened Res #2's door.

At 2:10 p.m., Res #2 was observed in his room sitting on his bed. He was looking for socks in his dresser. Res #2 was asked how long he had lived in the center, he replied for about a year. He was unable to recall where he lived prior to moving into the center.

At 2:14 p.m., when exiting Res #2's room, Res #1 was standing in the doorway. Res #1 did not enter the room.

At 2:45 p.m., LPN #1 was asked how Res #1 and Res #2 were protected after the incidents. She

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C1512	Continued From page 9	C1512		

stated, "[Res #2] kept his door locked, and staff redirected Res #1 if he got to the end of the hall." LPN #1 was asked if the two residents were cognitively intact to consent to sexual relations. She stated, "In memory care... so, No."

At 3:36 p.m., CNA #3 was asked what was done with the two (Res #1 and #2) residents involved on 12/29/2021. She replied, I brought [Res#1] out of the room and kept him in sight till I left at 10 p.m. She was asked if she notified her supervisor. She replied yes, I texted LPN #1 and also gave report to the next shift.

At 3:44 p.m., the ED was asked if other staff that worked in the memory care were interviewed during the investigation. She replied, no.

On 01/25/22 at 9:09 a.m., Res #1 was observed wandering the hallway with another resident.

At 11:35 a.m. LPN #1 was asked what interventions were in place to prevent/protect Res #1 after the incident. She stated, "I don't think there's anything on the care plan." Res #2's care plan was reviewed with LPN #1. She was asked what interventions were in place to prevent/ protect Res #2. She stated, "There is none."

At 1:31 p.m., CNA #2 was asked to review the statements she had written involving Res #1 and Res #2. She was asked if she witnessed the incident that she described on 12/28/21. She stated, "Yes." She was asked if she had witnessed the interaction on 12/29/21 involving Res #1 and Res #2. She stated, "Yes, I went in with ...[CNA#3]." CNA #2 acknowledged there were two separate incidents.

At 3:42 p.m., LPN #1 was asked if staff from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5513	A. BUILDING: ______ B. WING ______	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVEER AT QUAIL CREEK	**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
C1512	Continued From page 10	C1512		

other shifts had been interviewed. She replied, no. LPN #1 was asked if the two residents were assessed after the incident. She stated, "I asked if they felt scared, was hurt, did they feel safe here." She was asked where that assessment/interview was documented. She stated, "It's not." LPN #1 was asked if staff were in-serviced after the incidents on sexual abuse and how to report. She stated, there were no in-services after the reported incidents.

At 3:28 p.m., Res #1's family member was asked how Res #1 would feel about what happened between [Res #1] and [Res #2]. He stated, "If he was in his right mind, he wouldn't feel good about it at all."

On 01/26/22 at 10:09 a.m., the ED was asked if there was any documentation of staff training on abuse. She stated, "We no longer have access to [computer] records training." She was asked if there was any staff training documentation the center kept on site. She was not sure. No training documentation was provided by the ED

At 4:06 p.m., the ED was asked how she was informed about the incident between Res #1 and Res #2. She stated, "Res #1's [family member] called me at 7 oclock and told me on 12/29/21"

At 4:10 p.m., LPN #1 was asked if CNA #3 had texted her on 12/29/21 about the incident. She stated, "No, she came to me and told me." She was asked at what time. She stated, it was on the 2-10 shift on 12/29/21.

OKLAHOMA
State Department
of Health

Delivery via email to: JTownsend@proveersl.com

March 15, 2022

License Number: AL5513

Ms. Jillian Townsend, Executive Director
Proveer At Quail Creek
12928 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: NJT211

Dear Ms. Townsend:

On **January 27, 2022,** a complaint investigation was conducted at your Assisted Living Center. 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 **April 1, 2022**.

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,

Tempal Killman
Digitally signed by Tempal Killman
Date: 2022.03.15 09:04:47 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care | Enforcement Division
Oklahoma State Department of Health

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 2/26/2022
	Facility Name: Proveer at Quail Creek
	License Number: AL5513
	Survey Event ID: NJT211
	Date Survey Completed: 1/27/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1512	Based on: This REQUIREMENT is not met as evidencedby:On 01/25/22 at 4:48 p.m., the Oklahoma StateDepartment of Health (OSDH) confirmed the existence of an immediate jeopardy related to the center's failure to protect residents from sexual abuse. The center failed to assess the two residents involved and update care plan interventions; and failed to assess if other residents were at risk for sexual abuse. Additionally, the center failed to educate staff to identify, prevent and report sexual abuse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All memory care residents have been assessed for wandering and at risk sexual behaviors. All residents identified to have at risk behaviors have an updated service plan which includes interventions that will assure safety for all residents.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All memory care residents will be routinely assessed. If wandering or at risk sexual behavior is identified, the resident service plan will be updated and interventions will be put in place to protect all residents.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All memory care residents will be routinely assessed. If wandering or at risk sexual behavior is identified, the resident service plan will be updated and interventions will be put in place to protect all residents. All staff have been in-serviced on identifying, preventing and properly reporting sexual abuse. Ongoing training will be provided to staff in order to identify, prevent and properly report sexual abuse.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Monthly in-service trainings will be held and will include education on how to identify, prevent and properly report sexual abuse. Random audits of nursing notes will be conducted to ensure proper documentation and identification of at risk behavior. Audits will be reviewed during QA meetings Audits reviewed will be kept with QA minutes

OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/1/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date** Enter a date of signature. 3/9/22

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor**: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/26/2022** **Facility Name:** Proveer at Quail Creek **License Number:** AL5513 **Survey Event ID:** NJT211 **Date Survey Completed: 1/27/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C711	Based on: This Rule is not met as evidenced by:C 711 Based on observation and interview the center failed to ensure emergency exit doors were not pad locked shut to prevent an emergency exit.This had the potential to affect 21 of 21 residents who resided in the memory care unit.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	For the safety of the residents at Proveer at Quail Creek and to remain in accordance with the State building and safety regulations, all emergency exits are free of any lock which could hinder the safe exit from the building in the event of an emergency.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents were potentially affected. No residents were harmed.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The two padlocks were removed immediately.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Innappropriate locking mechanisms have been removed from the building and are not available for use. All emergency exits will be checked regularly to ensure they are free from anything which could possibly prevent safe exit from the building should an emergency occur. Function of emergency exits will be checked during monthly fire drills and reviewed during QA meetings. Monthly fire drill checklist will be kept with QA meeting minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/1/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. J Townsend	**Date**	Enter a date of signature. 3/7/22

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ **Acceptable** ☐ **Unacceptable** Date: Click here to enter a date. **Surveyor:** Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. **Facility in Compliance by:** Click here to enter a date.

OKLAHOMA
State Department
of Health

Delivery via email to: sstatum@proveersl.com

December 20, 2022

License Number: AL5513

7021 2720 0002 0354 7893

Ms. Skye Statum, Administrator
Proveer at Quail Creek
12928 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: NJT212

Dear Ms. Statum:

A revisit conducted **December 19, 2022**, revealed that your facility corrected deficiencies effective **April 1, 2022**.

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

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Manager
Long Term Care
Protective Health Services

Enclosure:

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
	AL5513	A. BUILDING: ______ B. WING ______	R 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVEER AT QUAIL CREEK	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 000}	INITIAL COMMENTS A revisit was conducted on 12/14/22 and 12/16/22. The facility was in substantial compliance.	{C 000}		

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