OKLAHOMA
State Department
of Health

Delivery via email to: sstatum@proveersl.com

September 7, 2022

License Number: AL5513

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

Survey Event ID: B5QT11

Dear Ms. Statum:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **August 30, 2022**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

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

Sincerely,

Katie Stagner
Digitally signed by Katie Stagner
Date: 2022.09.07 09:31:32 -05'00'

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Proveer at Quail Creek**
Address: **12928 North May Avenue**
City, State, Zip: **Oklahoma City, Ok, 73120**
Provider #: **AL5513 / ALC**
Complaint #: **OK00059336**
Investigation Date(s): **August 29th-30th, 2022**

ALLEGATION	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure residents' rights to self-determination were protected.	**US**

☐ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 08/22/2022 at 8:26 a.m.

A sample of seven residents including any identified resident, 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 specific to the facility ensuring residents' rights to self-determination were protected was conducted.

Clinical records were reviewed for resident assessments and care plans. Visit Coordination Notes for 3rd party providers were reviewed and documented residents right to refuse services. Facility grievance reports and resident council minutes were reviewed.

Staff was observed providing care as needed and upon residents' request. They were observed knocking on resident apartment doors and asking residents permission to enter. Meals were delivered individually to residents apartments or residents were served in the dining rooms according to their preference.

Residents stated they were able to make choices in all aspects of their care, especially regarding meals, bathing, getting up, and when to go to bed. They stated staff responded timely when they called for assistance in their apartments and they were treated with dignity and respect. Staff stated resident's rights to self determination were always respected.

At the time of the investigation there was no deficient practice related to ensuring residents' rights to self-determination were protected

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.

Ernestine Scovens

Ernestine Scovens RN, MSN, CHFS

Date report completed: 08/31/2022

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
	AL5513	A. BUILDING: _____ B. WING _____	08/30/2022

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 complaint investigation (#OK00059336) was conducted from 08/29/22 through 08/30/22. No deficiencies were cited.	C 000		

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