OKLAHOMA
State Department of Health

Delivery via email to: sstatum@proveersl.com

January 5, 2023

License Number: AL5513

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

Survey Event ID: P04311

Dear Ms. Statum:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **January 3, 2023**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

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

Sincerely,

Katie Stagner

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Proveer at Quail Creek**
Address: **12928 North May Avenue**
City, State, Zip: **Oklahoma City, Ok, 73120**
Provider #: **AL5513**
Complaint #: **OK00059923**
Investigation Date: **01/03/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility neglected to provide a safe and secure environment to prevent resident elopements.	**US**

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

An unannounced on-site investigation was initiated 01/03/2023 at 11:15 a.m.

A sample of three residents including any identified residents, were 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 unsubstantiated related to this allegation.

Upon entry and throughout the investigation there were no observations of residents exit seeking. Staff was observed assisting and redirecting residents as needed.

Observations were made of all exit doors both inside the secured unit and outside on the courtyard gates. All were secure and in working order.

Facility records were reviewed. Staff had been in-serviced and the doors monitored routinely.

Resident interviews were attempted, no exit seeking statements were made.

Staff interviewed stated proper procedure for missing residents, and interventions to ensure all residents were accounted for as they did walking rounds every shift and every two hours and as needed. Additional staff had been provided to the secure unit. Staff had identified high risk for elopement residents to ensure those residents were monitored often.

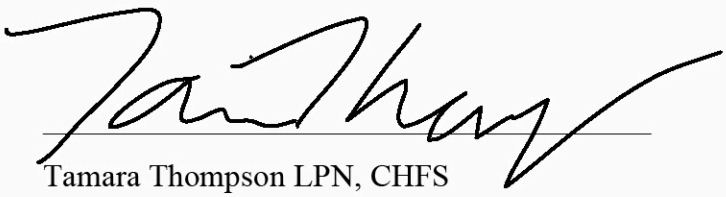
At the time of the investigation there was no deficient practice related to the facility neglecting to provide a safe and secure environment to prevent resident elopements.

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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Tamara Thompson LPN, CHFS

Date report completed: 01/04/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5513	A. BUILDING: _____ B. WING _____	01/03/2023

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 (#OK00059923) was conducted on 01/03/23. No deficiencies were cited.	C 000		

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