OKLAHOMA
State Department
of Health

Delivery via email to: sstatum@proveersl.com

March 30, 2023

License Number: AL5513

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

RE: Survey Event ID: CGU311

Dear Ms. Statum:

On **March 9, 2023**, agents from our office concluded a State Licensure survey in conjunction with a complaint investigation 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 **March 9, 2023.**

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;

(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) 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

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Proveer at Quail Creek**
Address: **12928 N May Ave**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5513**
Complaint #: **OK00059164**
Investigation Date(s): **03/03/23, 03/06/23 through 03/09/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure medications were administered according to physician's orders and were available in the facility.	**US**
2. The facility failed to ensure residents' rights to protected health information was not violated.	**US**
3. The facility failed to ensure call lights were answered in a timely manner.	**US**

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

An unannounced on-site investigation was initiated on 03/03/2023 at 1:20 p.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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 medication administration and medication availability was conducted.

Records were reviewed.

Medication administration was observed. Medication availability was observed.

At the time of the survey, no resident complained about their physician ordered medication.

At the time of the survey, the staff stated they administered medication according to the physician's order.

At the time of the survey, there was no deficient practice related to physician ordered medications or medication availability.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the protection of resident health information was conducted.

Policies, in-services, and resident rights were reviewed.

At the time of the survey, no staff were observed disclosing resident health information in any public/open area.

At the time of the survey, no resident complained about staff disclosing health information.

At the time of the survey, staff stated they did not discuss resident health information in the kitchen, dining room, or yelling down the halls.

At the time of the survey, there was no deficient practice related to privacy and protection of health information.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to call lights answered in a timely manner was conducted.

The call light system was reviewed.

Staff were observed answering their call light system.

At the time of the survey, no resident complained about the call lights.

At the time of the survey, staff stated they answered the call lights.

At the time of the survey, there was no deficient practice related to call lights.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1-#3. 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.

Melissa Swaim RN

Date report completed: 03/09/2023

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Proveer at Quail Creek**
Address: **12928 N May Ave**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5513**
Complaint #: **OK00060207**
Investigation Date(s): **03/03/23, 03/06/23 through 03/09/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered according to physician's orders.	**US**
2. The center failed to have adequate system to receive resident medications from the ordering pharmacy.	**US**
3. The center failed to have adequate staff to provide care for dependent residents.	**US**

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

An unannounced on-site investigation was initiated on 03/03/2023 at 1:20 p.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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 medication administration was conducted.

Records were reviewed.

Medication administration was observed.

At the time of the survey, no resident complained about not receiving their physician ordered medications.

At the time of the survey, staff stated they administered medications as ordered by the physician.

At the time of the survey, there was no deficient practice related to the administration of physician ordered medications.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to ordering and receiving medications was conducted.

Records were reviewed.

At the time of the survey, no resident complained about not receiving their physician ordered medications.

At the time of the survey, staff stated they administered medications as ordered by the physician.

At the time of the survey, there was no deficient practice related to pharmaceutical services.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to staffing was conducted.

Staff were observed throughout the survey.

At the time of the survey, no resident complained about staff not providing care.

At the time of the survey, staff stated they provided care to residents.

At the time of the survey, there was no deficient practice related to staffing.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1-#3. 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.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 03/09/2023

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 _____	03/09/2023

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 relicensure survey was conducted 03/03/23, and 03/06/23 through 03/09/23. Complaint investigations (#OK00059164 and #OK00060207) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. 2x-two times CPR-cardiopulmonary resuscitation LLE-left lower extremity LPN-licensed practical nurse LTCA-long term care aide nonsurg-nonsurgical	C 000		
C 711 SS=D	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 record review, observation, and interview the center failed to have a current fire	C 711		

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 _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 711	Continued From page 1 marshal's inspection report for the center. Findings: On 03/07/23 at 4:25 p.m., the administrator stated the last fire marshal had been completed 01/13/22.	C 711		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide evidence of CPR and first aid training for two (LTCA #2 and LTCA #3) of four sampled direct care staff employees. Findings: On 03/09/23 at 1:25 p.m., during record review, the business office manager stated there was no documentation LTCA #2 (hired 02/13/23) and LTCA #3 (hired 02/21/23) had completed CPR and first aid training.	C 954		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care	C5010		

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 _____	03/09/2023

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

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C5010	Continued From page 2 A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on record review and interview, the center failed to coordinate care with the home health company to ensure wound care was completed as ordered by the physician for two (#1 and #7) of two resident's who had a wound and was on	C5010		

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 _____	03/09/2023

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
C5010	Continued From page 3 home health. Findings: Resident #1 had diagnoses which included hypertension, Parkinson's disease, and coronary artery disease. Resident #1 admitted to the center 10/13/22 with a wound to their coccyx area being treated with medi honey and home health services. A "Home Health Certification and Plan of Care," dated 02/15/23, read in part, "...pressure ulcer of sacral region, unstageable...pressure ulcer of sacral region, stage 2..." A physician order, dated 02/15/23, read in part, "...pharmacy compounded medication...wound cleanser...cleanse pressure ulcers to inferior and superior sacrum three times weekly...wound care...hydrogel-apply to inferior and superior sacrum wounds three times weekly...collagen and alginate-cover inferior and superior sacral wounds three times weekly...barrier cream-apply daily and as needed to buttocks..." A physician order, dated March 2023, read in part, "...wound care...skilled nurse to perform wound care to new open area to distal coccyx pressure ulcer, cleanse with normal saline, pat dry, apply hydrogel to wound bed only, cover with alginate and cover with bordered foam three times weekly...Skilled nurse to perform twice weekly and mobile wound care to perform once weekly..." There were no skilled nursing notes by the center's nurse to monitor or describe the wounds by color, drainage, smell, dimension, depth, or	C5010		

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 _____	03/09/2023

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
C5010	Continued From page 4 treatment, at the time of the survey to ensure they were coordinating care with the third party provider. Resident #7 had diagnoses to include Type 2 diabetes mellitus with neuropathy, coronary artery disease, hypertension, and chronic heart failure. Resident #7 admitted to the center 11/23/22 with wounds to their lower extremities and redness to their buttocks. A "Home Health Certification and Care Plan," dated 01/20/23, read in part, "...encounter for change or removal of nonsurg wound dressing...dressing supplies...skilled nurse may perform acute wound care...patient's potential benefits of services...improved wounds and skin integrity...skilled nurse to assess skin for breakdown every visit...skilled nurse to assess/evaluate wound(s) at each dressing change and prn for signs/symptoms of infection...skilled nurse to perform inspection of patient's lower extremities every visit and report any alteration in skin integrity...skilled nurse to perform wound care using aseptic technique to LLE: cleanse with normal saline, pat dry with gauze, apply calcium alginate dressing to wounds, cover with xeroform, wrap with kerlix...may change prn soilage or dislodgement...skilled nurse to perform 2x weekly until healed..." There was no skilled nursing notes by the center's nurse to monitor or describe the wounds by color, drainage, smell, dimension, depth, or treatment, at the time of the survey to ensure they were coordinating care with the third party provider.	C5010		

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 _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
C5010	Continued From page 5 On 03/09/23 at 2:04 p.m., during record review with LPN #1, they stated they had no documentation of their own to ensure the wounds were improving or the treatments were effective. LPN #1 stated the visit coordination notes should have had a signature by a nurse from the center. When asked about observations of wounds, LPN #1 stated they had not seen them themselves. LPN #1 stated it would be important to monitor, measure, and document about wounds to ensure resident's were receiving services by third party providers.	C5010		

OKLAHOMA
State Department
of Health

Delivery via email to: sstatum@proveersl.com

April 18, 2023

License Number: AL5513

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

Survey Event ID: CGU311

Dear Ms. Statum:

On **March 9, 2023,** a Relicensure survey and a complaint investigation were 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 **June 9, 2023**.

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: 2023.04.18 13:44:39 -05'00'

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/13/2023** **Facility Name:** Proveer at Quail Creek **License Number:** AL5513 **Survey Event ID:** CGU311 **Date Survey Completed: 3/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C711	Based on: Based on record review, observation, and interview the center failed to have a current fire marshal's inspection report for the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is a Plan of Correction for Proveer at Quail Creek regarding the statement of deficiencies by OSDH on the date of 03/09/2023. The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

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?	Assisted Living community will comply with applicable construction and safety standards pursuant to title 74 O.S. Section 317 through 324.21. by obtaining a current fire marshal inspection through the OKC Fire Department office.
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 residing in the Community were potentially affected.
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?	Administrator has called the OKC Fire Department and requested for a fire marshal inspection to be done immedatley and has paid for the inspection. This request has been documented and added to the QA minutes. Adminstrator will provide training to the Business Office manager and the maintenance staff on OSDH regulation 310:663-7-(A) General Requirement, and Annual Due Date. The training will be added to the QA minutes. Administrator, Business Office Manager, and or maintenance staff will request a fire marshal inspection 90 days in advance of due date. The request will be documented, dated and then added to the QA minutes.
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	Administrator will obtain a current fire marshal inspection. Adminstrator will review fire marshal report 90 day prior to due date in QA meetings and obtain documentation on request to inspect. The documentation will be added to QA meetings.

C711

center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	90 day prior date will be established based off of last current inspection date and will be added to QA meetings. Inserve of training to Business office manager and maintenance staff on OSDH regulation 310:663-71(a) Adminstrator will monitor fire marshal inspection due date 90 day prior and add due date to QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/9/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Skye Statum Skye Statum, ADM OAC 310:663-25-4(F)		**Date 4/13/2023**

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: 4/13/2023** **Facility Name:** Proveer at Quail Creek **License Number:** AL5513 **Survey Event ID:** CGU311 **Date Survey Completed: 3/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C954	Based on: Based on record review, and interview, the center failed to provide evidence of CPR and first aid training for two (LTCA #2 and LTCA #3) of four sampled direct care staff employees.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is a Plan of Correction for Proveer at Quail Creek regarding the statement of deficiencies by OSDH on the date of 03/09/2023. The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

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?	Staff member LTCA #2 and LTCA #3 no longer work for Assisted Living community. Assisted Living community going forward will abide by OSDH regulation 310:663-9-5(d)-Staff Qualifications (d) Assisted Living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident residing in the community were potentially affected. No residents were affected by this deficient practice. Administrator will inservice the Business Office Manager and Nurse on OSDH Regulation 310:663-9-5(d) and the inservice will be added to the QA meeting notes.
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?	Business office manager will perform an Audit on direct care staff and identify which direct staff need CPR/FA. Administrator will review and sign off on audit. Audit will be added to the QA meeting notes. Administrator, Business Office Manager and or Nurse will ensure that direct care staff has received CPR/FA training. Business office manager will create and maintain an updated spreadsheet. Administrator will review the spreadsheet monthly and sign the spreadsheet. The spreadsheet will be added to the QA meeting notes. A copy of the audit will be added to the QA meeting notes. Business office manager will create and maintain a training record on all new staff and sign off with signature to ensure the new direct care staff have received CPR/FA. Administrator will audit and sign off on this form. The form will be added to the QA

C954

	meeting notes.
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.	Administrator will audit the Business office manager spreadsheet once a month to ensure all direct care have been trained in CPR/FA. The documentation of the audit will be added to QA meetings. Business office manager will create and maintain a binder of direct care staff CPR/FA training. The binder will have a spreadsheet that will be monitored monthly by both the Adminostrator and Business Office Manager. ....
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/9/2023
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature **Skye Statum** Skye Statum, ADM OAC 310:663-25-4(F)	**Date 4/13/2023**

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: 4/13/2023** **Facility Name:** Proveer at Quail Creek **License Number:** AL5513 **Survey Event ID:** CGU311 **Date Survey Completed: 3/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C5010	Based on: Based on record review and interview, the center failed to coordinate care with the home health company to ensure wound care was completed as ordered by the physician for two (#1 and #7) of two residents who had wound and was on home health.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is a Plan of Correction for Proveer at Quail Creek regarding the statement of deficiencies by OSDH on the date of 03/09/2023. The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

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?	Administrator and Nurse will identify resident #1 and #7 home health agency, obtain current wound orders, meet with home health agency in order to ensure wound care orders are being followed as prescribed by physician.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident residing in the community were potentially affected. Assisted Living community Nurse will perform an audit of residents that currently have home health and open wounds. Audit will be reviewed by Administrator and signed off by Administrator. Administrator and or nurse will inservice home health agency on OSDH regulation 63 O.S. 1-890.8 (A-D) Care and Services- Coordination of Care. Inservice will include the required form the home health agency must complete per visit, the skin assessment, and weekly updates to be discussed with community nurse and or administrator. The Audit and inservice will be added to the QA meeting notes.
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?	Assisted Living community will identify any residents with open wound, create a list of residents names and home health agencies name. This list will be placed in front of a Skin Assessment binder. The Administrator will audit the the list and the list will be added to the QA meeting notes. Assisted Living nurse will complete a weekly skin assessment on residents with open wounds. Skin assessment, home health visit notes, and current 485-pysician order for wound will be placed in a skin assessment binder. The binder will be updated weekly and

C 5010	audited by Administrator and Nurse. The Audit will be added to the QA meeting notes.
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.	Assisted Living Nurse and administrator will require weekly documented meetings with home health to discuss physician orders, healing progress or lack of improvement of wound and any needed changes. This meeting will ensure coordination of care. The documentation of the meetings will be added to QA meetings. The skin assessment binder will be monitored by assisted living nurse and administrator weekly. A list of residents with open wound will be monitored by nurse and administrator and added to the QA meeting notes. ....
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/9/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye Statum** Skye Statum, ADM OAC 310:663-25-4(F)	**Date 4/13/2023**

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

June 30, 2023

License Number: AL5513

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

RE: Survey Event CGU312

Dear Ms. Statum:

On **June 28, 2023,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 9, 2023,** have now been corrected effective **June 9, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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-C 06/28/2023

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 revisit was conducted on 06/28/23. All deficiencies from the 03/09/23 were cleared.	{C 000}		

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