OKLAHOMA
State Department
of Health

Delivery via email to: sstatum@proveersl.com

May 17, 2023

License Number: AL5513

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

Survey Event ID: U7SX11

Dear Ms. Statum:

On **May 9, 2023,** 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.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Proveer at Quail Creek**
Address: **12928 N May Ave**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5513**
Complaint #: **OK00060564**
Investigation Date(s): **05/05/23 and 05/09/23**

ALLEGATION(S)

1. The center failed to ensure residents received medications as ordered by the physician.
2. The center failed to have and/or implement an effective method to order, re-order and ensure residents' medications were in the center.
3. The center has or is treating residents' above the level of care the center can provide and failed to prevent new or worsening pressure wounds.

An unannounced on-site investigation was initiated 05/05/2023 at 9:35 a.m.

A sample of 5 residents, including any identified residents, 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 Summary of Complaint Investigation:

An investigation related to medication administration records, physician orders, pain management, medication availability, medication orders/reordering, pharmaceutical services, level of care, assessments, care plans, contracts, pressure wounds, weights and policies was conducted.

Residents stated they received their physician ordered medications.

Residents stated they worked with physical therapy to regain strength.

Staff stated they administered medications as ordered by a physician.

Staff stated medications were re-ordered online, faxed, or called the pharmacy. They stated the pharmacy delivered the medications and together they accounted for each medication for each resident.

Staff stated residents were weighed upon admission, once a month, or as the physician ordered.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 05/09/2023

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 _____	05/09/2023

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 complaint investigation (#OK00060564) was conducted 05/05/23, 05/08/23, and 05/09/23. Listed below are abbreviations that will be used throughout this document. A-fib - atrial fibrillation CO - complained of ED - emergency department ER - emergency room L - left LAC - laceration	C 000		
C1914 SS=D	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on record review and interview, the center failed to report to the Department a head injury for one resident (#2) of one sampled resident who required treatment at a hospital. The Administrator identified 67 residents resided at the center. Findings:	C1914		

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 _____	05/09/2023

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
C1914	Continued From page 1 Resident #2 had diagnosis to include dementia and Alzheimer's disease. Incident/Accident reports were reviewed to include reportable and not reportable events. An Accident, Injury, or Acute Illness Policy, read in part, "...describe and document injury, accident...report contains the follow up, treatment and statement of final disposition and be maintained on file..." A First Responder Incident/Accident report, dated 04/12/23, read in part, "...9:30 p.m....bedside...resident sitting on the bed and bleeding...nurse notified 9:40 p.m....resident transported to ER..." A hospital record, dated 04/12/23, read in part, "...arrival time 2209 (10:09 p.m.)...Arrival Complaint...Head Injury...Fall...Unwitnessed fall...LAC & hematoma to L side of head...CO headache...Provide suture tray to patient bedside...Head Symptoms: asymmetrical...Face Symptoms: lesion(s), tenderness, localized swelling...Left periorbital swelling...Admit to Inpatient From the ED...Clinical Impression...Multifocal pneumonia (Primary)...Concussion with unknown loss of consciousness status, initial encounter...Facial laceration, initial encounter...Closed fracture of nasal bone, initial encounter... " A hospital record, dated 04/13/23, read in part, "...Diagnosis: Fall...Moderate vascular dementia...Multifocal pneumonia...Pneumonia of right upper lobe...Past Medical History...Diagnosis...A-fib...Seizure disorder...Ice To Affected Area Head..."	C1914		

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 _____	05/09/2023

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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C1914	Continued From page 2 On 05/08/23 at 3:09 p.m., the Administrator was asked if it was a reportable event. The Administrator stated they didn't think it was reportable unless they had a diagnosis of a head injury.	C1914		

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Delivery via email to: sstatum@proveersl.com

June 15, 2023

License Number: AL5513

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

Survey Event ID: U7SX11

Dear Ms. Statum:

On **May 9, 2023,** 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 **July 31, 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

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: 6/2/2023** **Facility Name:** Proveer at Quail Creek **License Number:** AL5513 **Survey Event ID:** U75X11 **Date Survey Completed: 05/09/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1914	Based on: record review and interview, the center failed to report to the Department a head injury for one resident (#2) of one sampled residentwho required treatment at a hospital.

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. nter 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?	Administrator will report to the department resident #2 head injury and hospitalization. Administrator and Nurse will perform an audit of all other residents incident reports and hospitlizations in order to identify if facility has failed to report. All failed reports will be reported as required and added to the QA minutes. Assisted Living facility will going forward abide by OSDH Regulation 310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Administrator and Nurse will perform an audit of all other residents incident reports and hospitlizations in order to identify if facility has failed to report. All failed reports will be reported as required and added to the QA minutes.
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 and or Nurse will train care staff on how to properly complete incident report and who to report. Administrator will train Nurse and Memory Care Director on OSDH Regulation 310:663-19-1(d) REPORTS TO THE DEPARTMENT. All training will be added to the QA minutes. Administrator and or Nurse will review incident reports and follow up on hospitalizations within 24hrs of the next business day to ensure reports are made to the department as required.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its	Administrator will create and maintain weekly a

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.	spreadsheet of all reports made to the department. The spreadsheet will be discussed and reviewed in the Qa minutes. Administrator and Nurse will discuss all incident reports for the month and compare the reports made to the department to ensure effectiveness. Administrtor and Nurse will both sign off on this audit and the audit will be added to the QA minutes. The spreadsheet of incident reports and audits will be added to the Qa minutes. The audits will be kept in a binder in the administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/31/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Skye C. Statum, Administrator, Executive Director OAC 310:663-25-4(F)	**Date 6/2/2023**

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

August 3, 2023

License Number: AL5513

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

Survey Event ID: U7SX12

Dear Ms. Statum:

On **August 1, 2023,** an offsite-paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 9, 2023,** have now been corrected effective **July 31, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
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-C 08/01/2023

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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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted 08/01/23. The center was in substantial compliance.	{C 000}		

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