OKLAHOMA
State Department
of Health

Delivery via email to: sstatum@proveersl.com

October 25, 2023

License Number: AL5513

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

Survey Event ID: W5CV11

Dear Ms. Statum:

On **October 16, 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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care | Enforcement Division
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 #: **OK00060634**
Investigation Dates: **10/13/23 and 10/16/23**

ALLEGATIONS

The center failed to ensure residents were not physically, verbally or psychosocially abused
The center failed to ensure residents' property was not misappropriated
The center failed to ensure residents' right to choose their own medical provider was honored.
The center failed to ensure medications were administered according to physician's orders.
The center failed to report an allegation of abuse to the State Agency (OSDH).

An unannounced on-site investigation was initiated 10/13/2023 at 8:22 a.m.

A sample of nine 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:

A tour of the Center was conducted upon entrance, and at other various times throughout the survey. Residents were observed for abuse. Medication administration was observed.

Facility policy and procedures were reviewed. Nurses' notes, physician orders, in-service, and employee training records were reviewed. Medication administration records and State reportable incidents were reviewed.

Residents and resident representatives were interviewed regarding medication administration, right to choose their own provider, and abuse. Staff were interviewed regarding facility policy and procedures for medication administration, abuse, resident rights to choose their own provider, and State reportable.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/20/2023

INVESTIGATIVE REPORT

Facility: **Proveer at Quail Creek**
Address: **12928 North May Avenue**
City, State, Zip: **Oklahoma City, OK, 73120**
Provider #: **AL5513**
Complaint #: **OK00060741**
Investigation Date(s): **10/13/23 and 10/16/23**

ALLEGATION(S)

The facility failed to ensure incontinent care was provided in a timely manner.
The facility failed to ensure a clean, sanitary, and odor-free environment.
The facility failed to ensure pharmacy procedures were followed according to the standard of care.

An unannounced on-site investigation was initiated 10/13/2023 at 8:22 a.m.

A sample of nine 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:

A tour of the center was conducted upon entrance and at other times throughout the survey. Resident rooms and common areas were observed for cleanliness and odors. Staff were observed administering medication and assisting residents with their ADL's. Observations were made of the medication carts and storage of the medication carts. Incontinent care and call lights were observed.

Resident records reviewed included assessments, physician orders, care plans, service plans, service notes, and service contracts.

Center policy and procedures were reviewed.

Residents were interviewed related to the provisions of the care they received at the center, the environment and their medications.

Staff members were interviewed regarding the center policies and procedures for environment, timely incontinent care and medication administration processes.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/20/2023

INVESTIGATIVE REPORT

Facility: **Proveer at Quail Creek**
Address: **12928 North May Avenue**
City, State, Zip: **Oklahoma City, OK, 73120**
Provider #: **AL5513**
Complaint #: **OK00061341**
Investigation Date(s): **10/13/23 and 10/16/23**

ALLEGATION(S)

The center failed to ensure residents were not neglected.
The center failed to have and/or implement an effective infection control policy.

An unannounced on-site investigation was initiated 10/13/2023 at 8:22 a.m.

A sample of six 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:

A tour of the center was conducted upon entrance and at other times throughout the survey. Residents rooms and common areas were observed. Staff interactions with residents were observed. Staff infection control practices were observed. Staff response to call lights and assisting residents with their ADLs was observed. Wound care and incontinent care were observed.

Resident records reviewed included assessments, physician orders, care plans, service plans, service notes, wound notes, and service contracts.

Facility policy and procedures were reviewed.

Residents were interviewed related to the provisions of the care they received at the center, meals and medications after hospitalization, wound care, and ADL assistance.

Staff members were interviewed regarding the facility policy and procedures for neglect, incontinent care, ADL's, infection control, medication, and wound care.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/20/2023

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 #: **OK00061343**
Investigation Dates: **10/13/23 and 10/16/23**

ALLEGATIONS

The center failed to ensure residents received medications as ordered by the physician, staff safely administered medications using the five rights of medication administration, according to standards of practice and medications and medication carts were locked and not accessible to residents or other staff members.
The center failed to notify the residents' representatives of a change in condition.
The center failed to ensure residents received ADL assistance and baths according to schedule.

An unannounced on-site investigation was initiated 10/13/2023 at 8:22 a.m.

A sample of 12 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Medications cart and medication storage rooms were observed. Residents were observed for hygiene and cleanliness. Medication administration was observed.

Facility policy and procedures were reviewed. Nurses' notes, physician orders, in-service, and employee training records were reviewed. Medication administration records were reviewed. Progress notes for resident's representative notifications and ADL logs were reviewed.

Residents and resident representatives were interviewed regarding medication administration, notifications of change in condition, and ADLs. Staff were interviewed regarding facility policy and procedures for medication administration and storage, ADLs, and resident representation notification of change in condition.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/20/2023

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 _____	C 10/16/2023

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 Complaint investigations (#OK00060634, OK00060741, OK00061341, and #OK00061343) were conducted on 10/13/23 and 10/16/23. Listed below are abbreviations that will be used throughout this document: ADL- activities of daily living ACMA- advanced certified medication aide APAP- acetaminophen HWD- health and wellness director MAR- medication administration record	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally	C1505		

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 _____	C 10/16/2023

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
C1505	Continued From page 1 incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure residents received their shower/bath according to their plan of care for two (#1 and #3) of three sampled residents reviewed for ADL's. The HWD identified 60 residents resided in the center. Findings: 1. Resident #1 had diagnoses which included pressure ulcer and type 2 diabetes mellitus with diabetic chronic kidney disease. Resident #1's bath schedule was Monday, Wednesday, and Friday weekly. A review of the unlabeled bathing documentation sheet dated 08/01/23 had blanks for five of five opportunities. Resident #1 was in the hospital the other opportunities for the month. No ADL documentation was in the residents clinical record for the month of September 2023.	C1505		

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 _____	C 10/16/2023

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
C1505	Continued From page 2 There were no refusals documented in the medical record. On 10/16/23 at 2:40 p.m., the HWD stated they were unable to locate the bathing documentation for the month of September 2023. They stated there was no documentation of baths given for the month of August 2023. On 10/16/23 at 4:13 p.m., the HWD stated they were unable to locate anymore bathing documentation for the month of August 2023. 2. Resident #3 had diagnoses which included hypertension and cerebral infarction. Resident #3's bath scheduled was Monday, Wednesday, and Friday weekly. An ADL work sheet, dated 08/01/23, documented Resident #3 had not received a bath for nine out of 13 opportunities. On 10/16/23 at 2:23 p.m., the HWD stated they could not locate any ADL records for September 2023. On 10/16/23 at 2:24 p.m., the HWD stated refusals were documented on the ADL worksheet. There were no refusals documented on the ADL worksheet. On 10/16/23 at 4:22 p.m., the HWD stated the center did not have an ADL policy.	C1505		

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 _____	C 10/16/2023

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
C1923	Continued From page 3	C1923		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were accurately documented on the medication administration record as administered for two (#2 and #4) of three sampled residents reviewed for medications. The HWD identified 60 residents resided in the center. Findings: The "Medication Administration-General Guidelines" policy, revised 09/01/12, read in part,	C1923		

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 _____	C 10/16/2023

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
C1923	Continued From page 4 "...The Punch, Initial, Give method of administration will be observed for each medication. Chart each medication as it is set up, then administer the medications to the correct resident...The individual who administers the medication dose records the administration on the resident's MAR directly after each medication is poured or punched out..." 1. Resident #2 had diagnoses which included chronic pain and dementia. A physician's order, dated 04/18/23, documented oxycodone/APAP 10-325 mg give one tablet by mouth every four hours as needed. Resident #2's May 2023 Narcotic count record documented 42 doses were signed out by multiple ACMAs. Resident #2's May 2023 medication administration record documented eight doses were signed out by multiple ACMAs. On 10/16/23 at 10:09 a.m., ACMA #2 stated narcotics were charted on the medication administration record and then the narcotic count sheet prior to administration. On 10/16/23 at 10:14 a.m., ACMA #2 stated the medication administration record had missing documentation to show oxycodone/APAP 10-325 mg was administered based on the narcotic count record. On 10/16/23 at 10:15 a.m., ACMA #2 stated they should have documented the administration on the medication administration record. On 10/16/23 at 10:20 a.m., the HWD stated	C1923		

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 _____	C 10/16/2023

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
C1923	Continued From page 5 ACMAs should follow the punch, initial, give method for medication administration. They stated the medication administration record and the narcotic count record should match. 2. Resident #4 had diagnoses which included dementia and arthritis. A physicians order, dated 03/31/23, documented hydrocodone/APAP 10-325 mg give one tablet by mouth every six hours as needed for pain or elevated temp. Review of Resident #4's medication administration record did not have documentation of any administration of hydrocodone/APAP for the month of October 2023 to correlate to the individual patient's narcotic record that had 14 doses signed out. On 10/13/23 at 9:23 a.m., Resident #4 stated they received their medication, but that they did not receive them timely. On 10/13/23 at 4:18 p.m., ACMA #1 stated the process for medication administration was to identify the resident, punch, initial and give the medication. Initial the medication was given. They stated the resident did not receive their hydrocodone/APAP according to the medication administration record for 10/23. ACMA #1 stated there should have been documentation on the medication administration record. On 10/13/23 at 4:22 p.m., the HWD stated the process for medication administration was to look at the medication administration record and verify the order. If a narcotic, then they would sign out on the narcotic sheet. They stated to punch, initial, give, and to sign out on the medication	C1923		

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 _____	C 10/16/2023

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
C1923	Continued From page 6 administration record as well. The HWD stated Resident #4 did not receive their hydrocodone/APAP according to the medication administration record for October 2023. They stated their should have been documentation on the medication administration record.	C1923		

OKLAHOMA
State Department of Health

Delivery via email to: sstatum@proveersl.com

November 27, 2023

License Number: AL5513

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

Survey Event ID: W5CV11

Dear Ms. Statum:

On **October 16, 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 **January 9, 2024.**

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/8/2023** **Facility Name:** Proveer at Quail Creek **License Number:** AL5513 **Survey Event ID:** W5CV11 **Date Survey Completed: 10/16/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: record review, and interview, the center failed to ensure residents received their shoer/bath according to their plan of care for (#1 and #3) of three sampled residents for ADL's.

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 11/08/2023. 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?	Resident #1 & #3 no longer live at Proveer Assisted Living community. Assisted Living community going forward will abide by OSDH regulation 310:663-15-1 & 63 OS 1-1918 (B)(5) RESIDENT RIGHTS-Medical Care.
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. Health & Wellness Director and Memory Care Director will perform an audit on residents ADL bathing documentation to identiy potential affected residents. Health & Wellness Director and Memory Care Director will inservice the Care Partners and Medication Partners on "How to Complete Daily ADL resident records" and on OSDH Regulation 310:663-15-1 & 63 OS 1-1918 (B)(5) RESIDENT RIGHTS-Medical Care. The audit and inservice will be reviewed by the Administrator and 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?	The Health & Wellness Director and Memory Care Director will perform weekly Audits on the ADL's bathing documentation to ensure the Care Partners are properly documenti bathing and or refusal. The Audits will be reviewed by the Administrator monthly and 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:	Health & Wellness and Memory Care Director will track residents lacking ADL bathing documentation and identify the care staff responsible for the documentation weekly. Re-training will be performed weekly by both of these

C1505 W5CV11 AL5513

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.	positions. Administrator will review the audits, tracking, and re-training of staff monthly to ensure service improvement. The documentation of the audits, tracking, and training of staff will be kept in a binder in the Administrators office. The Admninstator, Health & Wellness Director and Memory Care Director will review, sign, and date monthly and added to the QA meeting notes. Health & Wellness Director and Memory Care Director will ensure the care partners know the location of the ADL Binders- These rounds will be once a week and documented. The Rounds will be given to the Administrator weekly. The Administrator will review, sign and date. The documentation will be added to the QA meeting notes. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/9/2024
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Skye Statum Skye Statum, ADM OAC 310:663-25-4(F)	**Date 11/8/2023**
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: 11/8/2023** **Facility Name:** Proveer at Quail Creek **License Number:** AL5513 **Survey Event ID:** W5CV11 **Date Survey Completed: 10/16/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923	Based on: record review, and interview, the center failed to ensure medications were accurately documented on the medication administration record as administered for two (#2 & #4) of the three sampled residents reviewed for medications.

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 11/08/2023. 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?	Health & Wellness Director will audit both Resident #2 & #4 medication record weekly to ensure medications are properly and accurately aministered and documented. Health & Wellness Director will train Care Partner Medication Aides on "How to Properly Document routine and PRN Medications" Assisted Living community going forward will abide by OSDH regulation 310:663-19-2(a)(3) Medication Administration.
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. Health & Wellness Director and Memory Care Director will perform an audit on residents receiving PRN pain medication. Health & Wellness Director and Memory Care Director will inservice the Care Partner Medication Aides on "How to Properly Administer and Document PRN medications" and on OSDH regulation 310:663-19-2(a)(3) Medication Administration. The audit and inservice will be reviewed by the Administrator, signed, and dated and 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?	The Health & Wellness Director and Memory Care Director will perform weekly Audits on resdients that receive PRN pain medication and to ensure proper documentation of medications. The Audits will be reviewed by the Administrator, signed, and dated monthly and added to the QA meeting notes.
OSDH Response: Element accepted Yes ☐ No ☐	

C1923 W5CV11 AL5513

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.	Health & Wellness and Memory Care Director will track residents lacking proper medication documentation and identify the care partner medication staff responsible for the documentation weekly. Re-training will be performed weekly by both of these positions. Administrator will review the audits, tracking, and re-training of staff, sign, and date documentation monthly to ensure service improvement. The documentation of the audits, tracking, and training of staff will be kept in a binder in the Administrators office. The Admninstator, Health & Wellness Director and Memory Care Director will review, sign, and date monthly and add to the QA meeting notes. Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/9/2024
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature **Skye Statum** Skye Statum, HSM OAC 310:663-25-4(F)	**Date 11/8/2023**

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

January 16, 2024

License Number: AL5513

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

Survey Event ID: W5CV12

Dear Ms. Statum:

On **January 10, 2024,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 16, 2023,** have now been corrected effective **January 9, 2024.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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 01/10/2024

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 An offsite/paper revisit was conducted on 01/10/24. 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