
Delivery via email to: kchadwick@proveersl.com

May 13, 2024

License Number: AL5513

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

RE: Survey Event ID: Q20811

Dear Ms. Statum:

On **April 21, 2024**, agents from our office concluded a State Licensure survey with 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 **April 21, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care**. 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Proveer at Quail Creek
Address: 12928 North May Ave
City, State, Zip: Oklahoma City, OK 73120
Provider #: AL5513
Complaint #: OK00061658
Investigation Dates: 04/20/24 and 04/21/24

ALLEGATION(S)
The center failed to ensure adequate staff to meet the needs of the residents.
The center failed to ensure residents' representatives were notified of the person designated to receive complaints.

An unannounced on-site investigation was initiated 04/20/2024 at 8:24 a.m.

A sample of four 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:

Observations were made regarding care and services provided to the residents and qualified staff in sufficient numbers to provide care. Resident clinical records including medication records, assessments, contracts, incident reports, schedules, resident council, and policies and procedures were reviewed during the survey. Residents were interviewed about sufficient staff to provide care and the complaint and grievances procedures. Staff were interviewed about staffing and complaint procedures.

The attached State form, Statement of Deficiencies, 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: 05/05/2024

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/21/2024
NAME OF PROVIDER OR SUPPLIER PROVEER AT QUAIL CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 from 04/20/24 through 04/21/24. A complaint investigation (#OK00061658) was conducted in conjunction with the survey. Facility Census: 59 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aide DON - director of nursing INR- international normalized ratio MAR - medication administration record mg - milligram RN -registered nurse TAR - treatment administration record	C 000			
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to ensure the kitchen ceiling and floor were clean and in good repair. The "Assisted Living Resident Condition and Care Overview" report, dated 04/21/24 documented 59 residents resided in the center. Findings:	C 391			

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 391	Continued From page 1 A document titled, "Chapter 257 Food Service Regulations, read in part, "310:257-11-40. Premises, structures, attachments, and fixtures, repairing The physical facilities shall be maintained in good repair." The regulation also read, "310:257-11-41. Cleaning, frequency and restrictions (a) The physical facilities shall be cleaned as often as necessary to keep them clean." The center's undated "Dining and Nutritional Service Policies", read in part, "Food shall be stored, prepared and served in accordance with Chapter 257." On 04/20/24 at 9:39 a.m., tour of the kitchen was conducted the ceiling over the dish machine was observed to have a hole in the ceiling tile, the vent had a build up of black dirt and debris, the floor to the walk-in refrigerator and freezer was missing tile and had blackened areas on the tiled areas in the threshold and floor of the inside of the walk-in refrigerator. On 04/20/24 at 3:35 p.m., the dining service supervisor stated the floor tiles and the ceiling tiles were missing, and the vent was dirty. They stated the maintenance director was responsible for repairs in the kitchen.	C 391		
C 398 SS=E	310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE (e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department.	C 398		

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C 398	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure two (#1 and #2) of six sampled dietary staff responsible for food preparation attended a food service training program approved by the Oklahoma State Department of Health. The administrator identified 59 residents who received meals from the kitchen. Findings: An undated, "Dining and Nutritional" policy, read in part, "Food service training. All staff assisting in, or responsible for food preparation shall have attended a food service training program" The employee files were reviewed and documented Dining Service Employee #1 was hired on 08/27/22 and Dining Service Employee #2 was hired on 12/05/23. There was no documentation the employees had food service training. On 04/21/24 at 3:24 p.m., the food service supervisor stated the employees had not received food service training.	C 398		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of	C 522		

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C 522	Continued From page 3 the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed annually for three (#2, 6, and #7) of three sampled residents reviewed for comprehensive assessments. The administrator identified 59 residents who resided in the center. Findings: The center's undated "Service Provision, Evaluation and Service Plan" policy, read in part, "The community shall complete the comprehensive assessment in accordance with the following...once every twelve (12) months" 1. Resident #7 Resident #7 was admitted to the center on 08/04/22. Resident #7's clinical record did not contain an annual comprehensive assessment for 2023. On 04/21/24 at 11:55 a.m., the DON stated they could not find an annual comprehensive assessment for Resident #7. 2. Resident #2	C 522		

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C 522	Continued From page 4 Resident #2 was admitted to the center on 09/15/21. Resident #2's clinical record did not contain an annual comprehensive assessment for 2023. On 04/21/24 at 12:08 p.m., the DON stated Resident #2's annual comprehensive assessment had not been completed in 2023. Resident #6 Resident #6 was admitted to the center on 04/21/22 . Resident #6's clinical record did not contain an annual comprehensive assessment for 2023 or 2024. On 04/21/24 at 12:27 p.m. the DON stated the annual comprehensive assessment for Resident #6 had not been completed.	C 522		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the center failed to update/develop the care plan based on the resident assessment to include: a. fall interventions for two (#2 and #9) of two	C 552		

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C 552	Continued From page 5 sample residents who were reviewed for falls; and b. anticoagulation medication therapy side effects/precautions and/or interventions for one (#9) of one sample resident who was on a blood thinner. The "Assisted Living Resident Condition and Care Overview" report, dated 04/21/24, documented 59 residents resided in the center, 10 residents received home health services. Findings: The center's undated "Service Provision, Evaluation and Service Plan" policy, read in part, "The...community shall use the results of the resident's assessment...to develop a care plan for the resident, in consultation with the resident and the responsible party" 1. Resident #2 A document titled, "First Responder Incident/Accident Report", dated 09/12/23, documented Resident #2 had an unwitnessed non injury fall. A document titled, "Resident Assessment", dated 10/14/23, read in part, "Fall Risk...Assessed to be at risk and/or has fallen one time in the past year without injury" There were no interventions for falls documented on the "Resident Assessment" form. There was not a care/service plan in the clinical record. A document titled, "First Responder Incident/Accident Report, ", dated 03/12/24, documented Resident #2 was found in bed with	C 552		

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C 552	Continued From page 6 blood on their head and pillow, Resident #2 may have fallen and went back to bed, and had a big bump on the back of their head. The report documented Resident #2 was sent to the hospital. On 04/21/24 at 1:31 p.m., the DON stated Resident #2 did not have a care plan for falls and the "Resident Assessment" form did not document interventions put in place to prevent Resident #2 from falling. 2. Resident #9 A hospital document titled, "After Visit Summary", dated 09/04/23, documented Resident #9 had been seen at the hospital for a fall and had an initial diagnoses of head injury, and history of falling. A document titled, "Resident Assessment", dated 10/14/23, read in part, "Fall Risk...Assessed to be at risk of falling and/or has experienced multiple falls in the past 90 days, or required medical attention...Note: Complete the Mobility/Fall Risk Assessment with outcomes addressed on Service Plan." The assessment also read, "Coordination of Health Care Services...Physician ordered services include...Home Health...Resident does not currently have any physician-ordered services" There were no interventions for falls, no side effects or interventions for the use of blood thinners, or coordination of care with home health documented on the resident assessment form. A home health certification/plan of care documented Resident #9 was receiving home health services which included INR monitoring. (A	C 552		

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C 552	Continued From page 7 blood test to determine how long it takes for blood to clot.) A document titled, "First Responder Incident/Accident Report", dated 03/09/24, documented Resident #9 fell hit their forehead and had a bruise on the left side by their eye. A document titled, "First Responder Incident/Accident Report", dated 03/31/24, documented Resident #9 was found on the floor in their room and reported to the staff they had fallen. A physician order, dated 04/09/24, documented to administer Coumadin (blood thinner) 3 mg daily. A physician's order, dated 04/15/24, documented to obtain an INR every two weeks by the home health nurse. On 04/21/24 at 4:15 p.m., the DON stated Resident #9's resident assessment form did not document interventions for falls, or side effects to monitor for the use of blood thinners, the therapeutic range for the INR or coordination with home health.	C 552		
C 711 SS=F	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.	C 711		

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C 711	Continued From page 8 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure violations cited by the fire marshal were corrected. The administrator identified 59 residents who resided in the facility and 16 residents who resided on the second and third floor on the East halls of the building. Findings: A "Fire Department" report, dated 12/04/23, read in part, "...NOTICE OF VIOLATION...Accessibility -Stairs Operable/Unobstructed...ITEMS STORED IN STAIRWELL...[reinspection] Date 01/03/2024...Inspection comments: ELEVATOR OUT OF SERVICE. ALL ELEVATORS MUST BE FUNCTIONAL AND INSPECTED...ONE STAIRWELL HAS ITEMS BLOCKING EGRESS PATH. NO ITEMS CAN BE STORED IN STAIRWELL...ORDER to COMPLY: You are hearby required to correct said conditions immediately upon receipt of this notice. Failure to comply with the foregoing order before the date of such reinspection may render you liable to the penalties provided by law for such violation..." An undated document titled,"Resident Council Worksheet", read in part, "Maintenance...Elevator"	C 711		

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C 711	Continued From page 9 On 04/20/24 at 9:25 a.m., the elevator on the East side of the building was out of service. On 04/20/24 at 10:48 a.m., a large trash container and a large piece of cardboard was located in the stairwell. On 04/21/24 at 12:43 p.m., the administrator stated the elevator on the East side of the building had not been operational since 09/2023. On 04/21/24 at 4:55 p.m., the administrator stated the fire marshal had not been back to do the reinspection because the elevator had not been fixed by the scheduled reinspection date.	C 711		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN or pharmacy consultant for seven (#2, 5, 6, 7, 8, 9, and #10) of seven residents reviewed for medications.	C 921		

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C 921	Continued From page 10 The "Assisted Living Resident Condition and Care Overview" report, dated 04/21/24, documented 59 residents resided in the center. Findings: The center's pharmacy policies, revised 09/01/12 read in part, "The current Physician Orders, Treatment Administration Record...and the Medication Administration Record...should be reviewed by the RN against the previous months physician's orders, MAR and Tar at the beginning of each month. The RN should review these orders against the previous months orders and update as needed" There was no documentation Resident #2, 5, 6, 7, 8, 9 and #10's medications had been reviewed by an RN or pharmacist in 09/2023, 10/2023, 12/2023, 01/2024, 03/2024, or 04/2024. On 04/20/24 at 4:00 p.m., the sales director stated the monthly medication reviews had not been completed.	C 921			
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	C1505			

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C1505	Continued From page 11 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 incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were administered as ordered by the physician for four (#5, 7, 9, and 10) of seven sampled residents who were reviewed for medication administration. The administrator identified 56 residents who were administered medications by the staff. Findings: The center's "Medication Administration" policy, revised 09/01/12, read in part, "Medications are	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2024
NAME OF PROVIDER OR SUPPLIER PROVEER AT QUAIL CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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 12 administered in accordance with written orders of the attending physician." 1. Resident #5 had diagnoses which included anxiety. Resident #5's physician's order, dated 01/17/24, documented to administer alprazolam (A medication used to treat anxiety disorders.) 0.5 mg twice a day. Resident #5's MAR, dated 04/01/24 through 04/30/24, documented the alprazolam had not been administered on 04/18/24. On 04/21/24 at 11:31 a.m., the DON stated they had run out of medication and had to fax the physician to send a new prescription to the pharmacy because it was a controlled medication. The DON stated they expected the staff to reorder medication when the resident had a week supply on hand. The DON stated the staff responsible for medication administration could reorder medications. 2. Resident #7 Resident #7's physician's orders, dated 04/11/24, documented to administer cephalexin (antibiotic) 500 mg three times a day for two days. Resident #7's MAR, dated 04/01/24 through 04/30/24, documented the cephalexin had not been administered on 04/11/24, 04/12/24, or 04/13/24. On 04/21/24 at 11:55 a.m., the DON stated Resident #7 returned from the hospital with an order for cephalexin. They stated the staff ordered the medication, it came in late and staff	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2024
NAME OF PROVIDER OR SUPPLIER PROVEER AT QUAIL CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
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C1505	Continued From page 13 could not find the antibiotic. The DON stated the medication had a stop date and no longer showed it was due to be administered on the electronic MAR. 3. Resident #9 Resident #9's physician's order, dated 12/26/23, documented to administer Coumadin (blood thinner) 2 mg daily. Resident #9's MAR, dated 04/01/24 through 04/30/24, documented the Coumadin had not been administered on 04/01/24, 04/02/24, or 04/04/24. On 04/21/24 at 4:15 p.m., the DON stated they did not know why the Coumadin had not been administered as ordered. 5. Resident #10 had diagnoses which included osteoporosis Resident #10's physician's order, dated 11/02/22, documented to administer Fosamax (A medication used to treat osteoporosis.) 70 mg weekly on Monday. Resident #10's MAR, dated 04/01/24 through 04/30/24, documented the Fosamax had not been administered on 04/01/24 or 04/08/24. The MAR documented "waiting on pharmacy" for the reason the Fosamax was not administered. On 04/21/24 at 12:32 p.m., the DON stated they did not know why the Fosamax had not been administered.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2024
NAME OF PROVIDER OR SUPPLIER PROVEER AT QUAIL CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 12928 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120		
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C1920	Continued From page 14	C1920		
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to follow their medication storage policy for one of three medication rooms observed. The "Assisted Living Resident Condition and Care Overview" report, dated 04/21/24, documented 59 residents resided in the center. Findings: The center's "Medication Storage in the Facility" revised 09/01/12, read in part, "Medications and biologicals are stored safely and securely...The medication supply is accessible only to licensed personnel, certified medication aides, pharmacy personnel, or staff members lawfully authorized to administer medication...Medication rooms, carts, and medication supplies are locked" On 04/21/24 at 9:00 a.m., the medication room on the second floor was unlocked and unattended. The medication room contained a medication cart which was unlocked, the top of the cart contained multiple containers of medication, discontinued medications, and overflow medications. The inside of the medication cart contained multiple medications. On 04/21/24 at 9:02 a.m., CMA #1 was asked	C1920		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/21/2024
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C1920	Continued From page 15 about the medications in the medication room unsecured. They stated the medications on top of the medication cart were discontinued and overflow medications and the medications in the medication cart were overflow medications. They stated the medication room lock was not working. On 04/21/24 at 9:04 a.m., after the interview was concluded CMA #1 attempted to lock the medication room door, it would not lock. The CMA left the medication room unlocked and unattended with medications on top of the unlocked medication cart. On 04/21/24 at 11:40 a.m., the DON stated the medication room should not have been unlocked and unattended.	C1920			
C1923 SS=E	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.	C1923			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2024
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C1923	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure medication error incident reports were documented and reported to the physician for two (#7 and #9) of two sampled residents who were reviewed for medication errors. The administrator identified 56 residents who were administered medications by the staff. Findings: The center's, "Medication Error and Adverse Drug Reaction Reporting" policy, revised 09/01/12, read in part, "Significant medication errors...documented and reported as appropriate to the resident's attending physician." The policy also read, "Medication Error...an omission of a vital medication." The policy also read, "The Administrator must receive a copy of the medication error report." 1. Resident #7 Resident #7's physician's orders, dated 04/11/24, documented to administer cephalexin (antibiotic) 500 mg three times a day for two days. Resident #7's MAR, dated 04/01/24 through 04/30/24, documented the cephalexin had not been administered on 04/11/24, 04/12/24, or 04/13/24. On 04/21/24 at 11:55 a.m., the DON stated they had not filled out a medication error report.	C1923		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2024
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C1923	Continued From page 17 2. Resident #9 Resident #9's physician's order, dated 12/26/23, documented to administer Coumadin (blood thinner) 2 mg daily. Resident #9's MAR, dated 04/01/24 through 04/30/24, documented the Coumadin had not been administered on 04/01/24, 04/02/24, or 04/04/24. Resident #9's laboratory results, dated 04/09/24, documented the INR (A lab test to determine how fast blood will clot.) was 1.1. A physician's order, dated 04/09/24, documented to increase Resident #9's Coumadin to 3 mg daily. On 04/21/24 at 4:15 p.m., the DON stated they had not notified the physician or filled out a medication error report for the Coumadin that was not administered as ordered. They stated the INR was 1.1 on 04/09/24 and the physician had increased the dose of Coumadin from 2 mg daily to 3 mg daily without being notified of the missed doses.	C1923		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care 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	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2024
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C5010	Continued From page 18 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 monitor home health services for one (#9) of one sampled resident who was reviewed for home health services. The "Assisted Living Resident Condition and Care Overview" report, dated 04/21/24, documented 10 residents received home health services. Findings: Resident #9	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2024
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C5010	Continued From page 19 A document titled, "Home Health/Hospice"list, documented Resident #9 was receiving home health services. Resident #9's physician's order, dated 12/26/23, documented to administer Coumadin (blood thinner) 2 mg daily. (Coumadin requires INR blood test to determine clotting time. The dosage is based on the INR levels.) There were no records in the facility of how often home health had been to see Resident #9 or were scheduled to see Resident #9, the INR results, therapeutic level for the INR, or home health plan of care. On 04/21/24 at 2:38 p.m., the DON stated Resident #9 received home health services for monitoring their INR levels related to Coumadin. The DON stated the facility did not have a copy of Resident #9's home health visits, home health recertification/plan of care, or most recent INR results. The DON stated they did not know Resident #9's therapeutic INR level. The DON stated they would call the home health company for the information.	C5010		

Delivery via email to: kchadwick@proveersl.com

May 23, 2024

License Number: AL5513

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

RE: Survey Event Q20811

Dear Ms. Chadwick:

On **April 21, 2024**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- C522 does not address how corrective action will be accomplished for the residents identified in the deficiency. (Will residents who did not have an annual comprehensive assessment be assessed.)
- C921 does not address the deficient practice cited. The medications are required to be reviewed monthly by the RN or the pharmacist. The POC does not address the corrective measures put in place for residents cited in the deficiency and what measures would be put in place to ensure the medications are reviewed monthly by the RN or pharmacist.
- C1920 does not address the door to the medication room that the staff were not aware of how to lock. (Was the lock fixed on the medication room door or were the staff in-serviced on how to lock the door using the key, the issue was the staff did not know how to lock the door and thought it was broken.)
- C1923 does not address how corrective action will be accomplished for the residents identified in the deficiency. (For example, was the physician notified, was a medication error report filled out?)

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/21/2024

Facility Name: Proveer at Quail Creek

License Number: AL 5513

Survey Event ID: Q20811

Date Survey Completed: 4/21/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391 SS=E

Based on: observation, record review, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to ensure the kitchen ceiling and floor were clean and in good repair.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Katherine Chabuch

Date Enter a date of signature.

5/22/24

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.

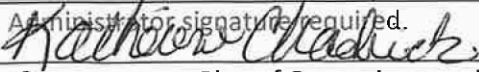
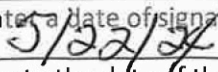
Items Below Are For OSDH Use Only

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 Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 5/21/2024		
	Facility Name: Proveer at Quail Creek		
	License Number: AL 5513		
	Survey Event ID: Q20811		
Date Survey Completed: 4/21/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 398	Based on: This Rule is not met as evidenced by:Based on record review and interview, the center failed to ensure two (#1 and #2) of six sampled dietary staff responsible for food preparation attended a food service training program approved by the Oklahoma State Department of Health.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter 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?		All current employees have completed food handlers training.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Any new dietary employees must complete food handlers training within the first week of employment.	
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?		Any new dietary employees must complete food handlers training within the first week of employment.	
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.		Enter methods to ensure corrections are sustained: Food Handlers training certificate will be put in the employee's file and business office manager will monitor. Any new dietary staff will be identified and food handlers training will be brought to QA to review. Business office manager will maintain food handlers training in employee file.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/8/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature.	
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 Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 5/21/2024		
	Facility Name: Proveer at Quail Creek		
	License Number: AL 5513		
	Survey Event ID: Q20811		
Date Survey Completed: 4/21/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 522	Based on: Based on record review and interview, the center failed to ensure comprehensive assessments were completed annually for three (#2, 6, and #7) of three sampled residents reviewed for comprehensive assessments		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter 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?		DON or designee will complete 10 chart audits weekly. Any outstanding comprehensive assessments will be completed upon discovery.	
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 charts will be audited to ensure timely completion of comprehensive assessments	
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?		Spreadsheet will be developed to track assessment due dates.	
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.		Enter methods to ensure corrections are sustained: ED, DON or designee will review weekly chart audits for completion. QA committee will review spreadsheet monthly x 2 months and then quarterly thereafter. Assessment Due Date spreadsheet will be updated with completion of assessment.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/8/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. 		Date Enter a date of signature. 	
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 Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 5/21/2024		
	Facility Name: Proveer at Quail Creek		
	License Number: AL 5513		
	Survey Event ID: Q20811		
Date Survey Completed: 4/21/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 552 SS=E	Based on: record review and interview, the center failed to update/develop the care plan based on the resident assessment to include:a. fall interventions for two (#2 and #9) of twosample residents who were reviewed for falls; andb. anticoagulation medication therapy side effects/precautions and/or interventions for one (#9) of one sample resident who was on a blood thinner		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter 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?		ADL Worksheet (i.e. careplan) will be updated with any fall interventions and medication side effects and made available to direct care staff. It will be updated with changes to the comprehensive assessment.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		ADL Worksheets (i.e. careplans) have been completed and put in a binder and are available on each floor.	
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?		QA will review ADL Worksheets (i.e. careplans) monthly for two months and then quarterly for three months.	
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.		Enter methods to ensure corrections are sustained: DON or designee will audit the binders on the floors weekly for six weeks to review the effectiveness of fall interventions. QA Committee will review the care plan binders monthly for two months. QA will review ADL Worksheets (i.e. careplans) monthly for two months and then quarterly for three months.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/8/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Katherine Chadiuk</i> OAC 310:663-25-4(F)		Date <i>5/21/24</i> Enter a date of signature.	
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			



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/21/2024

Facility Name: Proveer at Quail Creek

License Number: AL 5513

Survey Event ID: Q20811

Date Survey Completed: 4/21/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 711

Based on: Based on observation, record review, and interview, the facility failed to ensure violations cited by the fire marshal were corrected

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: East elevator currently inoperable, tagged by Fire Marshall.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Administrator signature required.
OAC 310:663-25-4(F)

Adeline Chabuck

Date Enter a date of signature.

5/22/24

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

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/21/2024

Facility Name: Proveer at Quail Creek

License Number: AL 5513

Survey Event ID: Q20811

Date Survey Completed: 4/21/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 921

Based on: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN or pharmacy consultant for seven (#2, 5, 6, 7, 8, 9, and #10) of seven residents reviewed for medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Boothaine Chadwick

Date

Enter a date of signature.

5/22/24

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

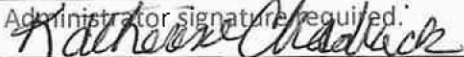
Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 5/21/2024		
	Facility Name: Proveer at Quail Creek		
	License Number: AL 5513		
	Survey Event ID: Q20811		
Date Survey Completed: 4/21/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 1505	Based on: record review and interview, the center failed to ensure medications were administered as ordered by the physician for four (#5, 7, 9, and 10) of seven sampled residents who were reviewed for medication administration.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter 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?		Medication Aides were inserviced by pharmacy consultant on ____ regarding medication orders and proper placement in medication room and cart.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Medication Cart Audits will be completed by DON or designee weekly for six weeks and then monthly thereafter to ensure medications are in the cart and available.	
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?		Pharmacy consultant has inserviced medication aides on policy regarding proper re-order procedure.	
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.		Enter methods to ensure corrections are sustained: Medication carts will be audited weekly for six weeks and then monthly thereafter. Medication Cart Audits will be reviewed in QA Committee meetings monthly for two months and then quarterly thereafter. Binder with Medication Cart Audits will be kept in a binder in the DON's office and available for review.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/8/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature.	
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Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 5/21/2024		
	Facility Name: Proveer at Quail Creek		
	License Number: AL 5513		
	Survey Event ID: Q20811		
Date Survey Completed: 4/21/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 1920	Based on: observation, record review, and interview, the center failed to follow their medication storage policy for one of three medication rooms observed.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter 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?		All medication administration staff have been inserviced on the medication storage policy.	
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 medication administration staff have been inserviced on the medication storage policy.	
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?		DON or designee will conduct monthly medication room spot checks for security.	
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.		Enter methods to ensure corrections are sustained: Monthly Spot check sheet will be reviewed by DON and any issues addressed. QA Committee will review check sheets during meetings. Binder will be made and kept in DON's office.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/8/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature. 5/22/24	
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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 Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 5/21/2024		
	Facility Name: Proveer at Quail Creek		
	License Number: AL 5513		
	Survey Event ID: Q20811		
Date Survey Completed: 4/21/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 1923	Based on: record review and interview, the center failed to ensure medication error incident reports were documented and reported to the physician for two (#7 and #9) of two sampled residents who were reviewed for medication errors.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter 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?	All medication administration staff were inserviced regarding Medication Error policy.		
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON or designee will perform MAR reviews weekly to ensure MARs are completed.		
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?	DON or designee will perform MAR reviews weekly to ensure MARs are completed.		
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.	Enter methods to ensure corrections are sustained: Weekly MAR audits will be performed for two months. QA Committee will review MAR audits at meetings monthly for two months and then quarterly. Binder will be kept in DON office with MAR audits.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	7/8/2024		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. 		Date Enter a date of signature. 5/22/24
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 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 5/21/2024		
	Facility Name: Proveer at Quail Creek		
	License Number: AL 5513		
	Survey Event ID: Q20811		
Date Survey Completed: 4/21/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 5010	Based on: record review and interview, the center failed to monitor home health services for one (#9) of one sampled resident who was reviewed for home health services.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter 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?		All residents with home health/hospice providers will have a 3 rd party binder/folder in the community.	
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 with home health/hospice providers will have a 3 rd party binder/folder in the community.	
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?		DON or designee will monitor third party services to coordinate care. Third party forms will be completed and turned into the DON. Third party communication forms will be reviewed and filed.	
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.		Enter methods to ensure corrections are sustained: QA will review Home Health/Hospice provider list and review the 3rd party binder monthly for two months and then quarterly x3. QA will review Home Health/Hospice provider list and review the 3rd party binder monthly for two months and then quarterly x3. Third party communication sheets will be filed in a binder in the DON's office and available for review.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/8/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature.	
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Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			

Delivery via email to: kchadrick@proveersl.com

June 6, 2024

License Number: AL5513

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

Survey Event ID: Q20811

Dear Ms. Chadrick:

On **April 21, 2024**, a Relicensure Survey with a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 8, 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, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/21/2024

Facility Name: Proveer at Quail Creek

License Number: AL 5513

Survey Event ID: Q20811

Date Survey Completed: 4/21/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391 SS=E

Based on: observation, record review, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to ensure the kitchen ceiling and floor were clean and in good repair.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature *Administrator signature required.*
OAC 310:663-25-4(F)

Date Enter a date of signature.

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.

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Facility in Compliance by: Click here to enter a date.



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/21/2024

Facility Name: Proveer at Quail Creek

License Number: AL 5513

Survey Event ID: Q20811

Date Survey Completed: 4/21/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 398

Based on: This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure two (#1 and #2) of six sampled dietary staff responsible for food preparation attended a food service training program approved by the Oklahoma State Department of Health.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All current employees have completed food handlers training.

Any new dietary employees must complete food handlers training within the first week of employment.

Any new dietary employees must complete food handlers training within the first week of employment.

Enter methods to ensure corrections are sustained:

Food Handlers training certificate will be put in the employee's file and business office manager will monitor.

Any new dietary staff will be identified and food handlers training will be brought to QA to review.

Business office manager will maintain food handlers training in employee file.

7/8/2024

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Kathleen Chadwick

Date Enter a date of signature.

5/22/24

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

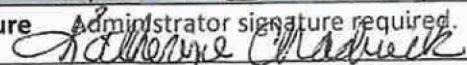
Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

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Facility in Compliance by: Click here to enter a date.

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 5/21/2024		
	Facility Name: Proveer at Quail Creek		
	License Number: AL 5513		
	Survey Event ID: Q20811		
			Date Survey Completed: 4/21/2024
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 711		Based on: Based on observation, record review, and interview, the facility failed to ensure violations cited by the fire marshal were corrected	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: East elevator currently inoperable, tagged by Fire Marshall.			
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?		Maintenance Director or designee will contact elevator repair company and schedule repair. Fire marshal will be contacted to inspect after repair. Stairwells will be visually checked for debris bi-weekly.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Fire marshal will be contacted to re-inspection after elevator repair. Maintenance director or designee will inspect stairwells bi-weekly.	
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?		Fire marshal annual inspection, Quarterly service inspection. Bi-weekly stairwell checks.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Enter methods to ensure corrections are sustained:	
a. How the correction will be evaluated for effectiveness;		Fire marshal will inspect annually. Stairwells will be visually checked bi-weekly.	
b. How the correction will be incorporated into the center's quality assurance system; and		QA committee will review all Fire marshal inspections upon completion.	
c. How monitoring records will be kept to evidence the correction.		Fire Marshall report will be kept in state binder.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/8/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required.  OAC 310:663-25-4(F)			Date Enter a date of signature. 5/22/24
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Facility in Compliance by: Click here to enter a date.			



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/21/2024

Facility Name: Proveer at Quail Creek

License Number: AL 5513

Survey Event ID: Q20811

Date Survey Completed: 4/21/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: Based on record review and interview, the center failed to ensure comprehensive assessments were completed annually for three (#2, 6, and #7) of three sampled residents reviewed for comprehensive assessments

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator's Signature required

Date Enter a date of signature.

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Addendum Date Enter a date of addendum.

Submitted by Enter name of person submitting addendum

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