OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@gardensatquailsprings.com

June 20, 2023

License Number: AL5514

Ms. Lisa Sanders, Administrator
Villagio of Oklahoma City
14300 North Portland
Oklahoma City, OK 73134

RE: Survey Event ID: SGY811

Dear Ms. Sanders:

On **June 6, 2023**, agents from our office concluded a State Licensure survey in conjunction with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **June 6, 2023**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Villagio of Oklahoma City**
Address: **14300 North Portland**
City, State, Zip: **Oklahoma City, OK, 73134**
Provider #: **AL5514**
Complaint #: **OK00060598**
Investigation Dates: **06/05/23 and 06/06/23**

ALLEGATIONS

1. The center failed to ensure residents' choices were honored.
2. The center failed to provide meals (specifically breakfast) in a timely manner and ensure dietary supplies.
3. The center failed to provide activities and exercise for residents and have an activities director on staff.
4. The center does not provide a clean, sanitary and homelike environment.
5. The center failed to ensure adequate staff to provide care for dependent residents.

An unannounced on-site investigation was initiated 06/05/2023 at 10:30 a.m.

A sample of 10 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 throughout the survey process. Residents were observed in their apartments, in common areas, during mealtimes, while participating in activities, and receiving assistance from staff. Staff were observed while providing resident care, during medication administration, when assisting residents with meals, during activities, and while responding to call lights.

Sampled clinical records were reviewed for assessments, physician orders, care plans, progress notes, service agreements, activities of daily living documentation, nutritional assessments and medication administration records. Staff scheduling for all departments were reviewed. Grievance logs, resident council meeting minutes, incident reports, and in-services were reviewed. Facility policies and procedures were reviewed.

Numerous residents, including sampled residents, were interviewed regarding housekeeping and the cleanliness of the facility. Residents were interviewed regarding choices being honored and activities being available.

Residents were interviewed regarding mealtimes and dietary supplies available. Housekeeping staff were interviewed regarding cleaning schedules and housekeeping being provided on weekends. Staff members were interviewed regarding when residents are assisted to bed, when medications are administered, and how resident choices are honored. Kitchen staff was interviewed regarding food supply and adequate staffing to serve meals as scheduled. Administration staff were interviewed regarding staff that conduct activities and transportation for residents.

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

Thank you for bringing your concerns to our attention.

Leah Mays

Digitally signed by Leah Mays
Date: 2023.06.19 17:02:38 -05'00'

Leah Mays, Clinical Health Facility Surveyor

Date report completed: 06/06/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Villagio of Oklahoma City**
Address: **14300 North Portland**
City, State, Zip: **Oklahoma City, OK, 73134**
Provider #: **AL5514**
Complaint #: **OK00060739**
Investigation Dates: **06/05/23 and 06/06/23**

ALLEGATIONS

1. The facility failed to ensure incontinent care was provided in a timely manner.
2. The facility failed to provide supervision to prevent accidents.

An unannounced on-site investigation was initiated 06/05/2023 at 10:30 a.m.

A sample of 10 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 throughout the survey process. Residents were observed in their apartments, in common areas, during mealtimes, while participating in activities, and while receiving assistance from staff with activities of daily living. Staff were observed while providing resident care, during medication administration, when assisting residents with meals, during activities, and while responding to call lights.

Sampled clinical records were reviewed for assessments, physician orders, care plans, progress notes, service agreements, activities of daily living documentation, and medication administration records. Staff schedules were reviewed. Staff qualifications and licenses was reviewed. Grievance logs, resident council meeting minutes, incident reports, and in-services were reviewed. Facility policies and procedures were reviewed.

Numerous residents, including sampled residents, were interviewed regarding housekeeping and the cleanliness of the facility. Residents were interviewed regarding assistance and supervision they received from staff to prevent falls and provide personal care. Staff members were interviewed regarding their ability to supervise

residents to prevent falls and provide residents with timely assistance. Administration was interviewed regarding adequate and competent staffing.

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

Thank you for bringing your concerns to our attention.

Leah Mays

Digitally signed by Leah Mays
Date: 2023.06.13 16:12:42 -05'00'

Leah Mays, Clinical Health Facility Surveyor

Date report completed: 06/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5514	A. BUILDING: _____ B. WING _____	C 06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGIO OF OKLAHOMA CITY	14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134

(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 re-licensure survey was conducted from 06/05/23 through 06/06/23. Complaint investigations (#OK00060598 and #OK00060739) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. LPN - Licensed Practical Nurse RN - Registered Nurse	C 000		
C 397 SS=D	310:663-3-8(d)(4) FOOD STORAGE, PREPARATION AND SERVICE (4) Only clean, whole eggs with shell intact, pasteurized liquid, frozen, dry eggs, egg products and commercially prepared and packaged hard boiled eggs may be used. All eggs shall be thoroughly cooked except pasteurized egg products or pasteurized in-shell eggs may be used in place of pooled eggs or raw or undercooked eggs. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure only pasteurized eggs were used and thoroughly cooked. The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 60 residents resided in the facility. Findings:	C 397		

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C 397	Continued From page 1 The facility's "Food Safety" policy, no dated, read in part, "...To provide food that is free from contamination thus risking the health and well being of the residents and staff...Food will be served in such a way as to prevent growth of bacteria..." On 06/05/23 at 10:45 a.m., during observation of the kitchen, unpasteurized eggs were present in the walk-in refrigerator. On 06/05/23 at 10:50 a.m., the dietary manager was asked if the facility used pasteurized eggs to serve to residents. The dietary manager reported a staff member had dropped the container of pasteurized eggs and they had to buy unpasteurized eggs until the food truck arrived. The dietary manager reported only scrambled eggs had been served that morning. On 06/06/23 at 8:50 a.m., an unidentified resident was observed to have over-easy fried eggs for breakfast. The resident reported they had ordered over-easy fried eggs. On 6/06/23 at 9:00 a.m., the dietary manager was asked if they had received pasteurized eggs and had them available. The dietary manager reported no pasteurized eggs had been received but a delivery truck was expected. The dietary manager reported they only served pasteurized eggs to residents. The dietary manager was informed a resident had been served fried eggs over-easy that morning. The dietary manger confirmed the fried, over-easy eggs, served to the unidentified resident were prepared with unpasteurized eggs.	C 397		

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C 542	Continued From page 2	C 542		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's personal physician, for ten (#1, 2, 3, 4, 5, 6, 7, 8, 9 and #10) of ten sampled residents whose assessments were reviewed. The "Assisted Living Resident Condition and Care Overview" report, dated 06/06/23, documented 60 residents resided in the facility. Findings: The facility's "Nursing Assessments/Comprehensive" policy, dated 11/01/22, read in part, "...A full nursing assessment on each resident should be performed by the Wellness Director...When a full nursing assessment is conducted, a Resident Health Assessment form should be completed...Communicate with team and document appropriately..." 1. Resident #1 was admitted to the facility on 01/19/23. Resident #1's comprehensive assessment, dated 05/12/23, did not document the assessment had been coordinated and signed by an RN or the	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 542	Continued From page 3 resident's physician. 2. Resident #2 was admitted to the facility on 03/15/21. Resident #2's comprehensive assessment, dated 05/10/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician 3. Resident #3 was admitted to the facility on 05/11/23. Resident #3's comprehensive assessment, dated 05/11/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 4. Resident #4 was admitted to the facility on 08/08/22. Resident #4's comprehensive assessment, dated 04/10/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 5. Resident #5 was admitted to the facility 02/28/23. Resident #5's comprehensive assessment, dated 02/28/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 6. Resident #6 was admitted to the facility on 08/08/22. Resident #6's comprehensive assessment, dated 05/15/23, did not document the assessment had been coordinated and signed by an RN or the	C 542		

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C 542	Continued From page 4 resident's physician 7. Resident #7 was admitted to the facility on 03/15/21. Resident #7's comprehensive assessment, dated 04/14/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician 8. Resident #8 was admitted to the facility on 12/10/21. Resident #8's comprehensive assessment, dated 04/06/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 9. Resident #9 was admitted to the facility on 03/19/21. Resident #9's comprehensive assessment, dated 04/13/23, did not document the assessment was coordinated and signed by an RN or the resident's physician. 10. Resident #10 was admitted to the facility on 03/25/22. Resident #10's comprehensive assessment, dated 04/17/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. On 06/06/23 at 1:30 p.m., the Wellness Director was asked about resident assessments not being signed by an RN. The Wellness Director reported an LPN had been hired to catch up all resident assessments, but the resident assessments had not been signed by an RN or	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 542	Continued From page 5 the resident's physician. The Wellness Director reported none of the above listed resident assessments had been signed.	C 542		
C 544 SS=E	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following: (1) the resident; (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and observation, the facility failed to maintain all resident assessments, for five years, for five (#1, 2, 7, 8, and #10) of 10 residents reviewed for resident assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 06/06/23, documented 60 residents resided in the facility. Findings: The facility's "Resident Records" policy, not dated, read in part, "...All resident files will be kept in a secured area...A resident's record will be retained for at least seven years..." 1. Resident #1 was admitted to the facility on 01/19/23. Resident #1's assessments since admission were requested from the Wellness Director. The	C 544		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 544	Continued From page 6 Wellness Director reported medical records prior to April 2023 were not available. 2. Resident #2 was admitted to the facility on 03/15/21. Resident #2's assessments since admission were requested from the Wellness Director. The Wellness Director reported medical records prior to April 2023 were not available. 3. Resident #7 was admitted to the facility on 03/15/21. Resident #7's assessments since admission were requested from the Wellness Director. The Wellness Director reported medical records prior to April 2023 were not available. 4. Resident #8 was admitted to the facility on 12/10/21. Resident #8's assessments since admission were requested from the Wellness Director. The Wellness Director reported medical records prior to April 2023 were not available. 5. Resident #10 was admitted to the facility on 03/25/22. Resident #10's assessments since admission were requested from the Wellness Director. The Wellness Director reported medical records prior to April 2023 were not available. On 06/06/23 at 1:45 p.m., the Wellness Director reported all medical records prior to 04/01/23 were documented in another electronic medical record. The Wellness Director reported new owners took over 04/01/23 and began using the	C 544		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 544	Continued From page 7 current electronic medical record and did not have access to electronic medical records prior to 04/01/23. On 06/06/23 at 4:00 p.m., the Executive Director was asked if the facility had access to the previous electronic medical records. The Executive Director reported the new owners were not given access to the previous electronic medical records used by the facility prior to 04/01/23.	C 544		

OKLAHOMA
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Delivery via email to: executivedirector@gardensatquailsprings.com

July 5, 2023

License Number: AL5514

Ms. Lisa Sanders, Executive Director
Villagio Of Oklahoma City
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: SGY811

Dear Ms. Sanders:

On **June 6, 2023,** a Licensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility** for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 30, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

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The Gardens at Quail Springs

ASSISTED LIVING & MEMORY CARE

July 3, 2023

Katie Stagner, Enforcement Analyst

LTCEnforcement@health.ok.gov

Re: Survey Event ID: SGY811

Dear Ms. Stagner:

Attached are the Plan of Corrections (POC) for the three (3) deficiencies cited by OSHD for The Gardens at Quail Springs.

If you have any questions or need additional information, please feel free to reach out to me at executivedirector@gardensatquailsprings.com or 405-413-0021.

Sincerely,

Lisa Sanders, ED

Lisa Sanders, Executive Director
The Gardens at Quail Springs

Enclosures

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/30/2023** **Facility Name:** The Gardens at Quail Springs (formerly Villagio) **License Number:** AL5514 **Survey Event ID:** SGY811 **Date Survey Completed: 6/6/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C397	Based on: Observation and interview, the facility failed to ensure only pasteurized eggs were used and thoroughly cooked.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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?	Dining Service Manager, Kitchen Staff and Community Leadership will attend an in-service given by our community dietitian which will review food storage, preparation and service of food including but not limited to types of eggs to be used and how to prepare.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents have the potential to be affectd by the alleged deficient practice.
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?	Dining Service Manager, Executive Director and/or designee will do checks of eggs to ensure that staff is preparing correct eggs in the manner requried. All dining employees as well as community leaders to be in-serviced by Wellness Director and Dietitan on review of food storage, preparation and service including but not limited to types of eggs to be used, the reasons and how to prepare.
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.	Dining Service Manager and/or designee will check eggs in the refrigerator to ensure pasteurized eggs are being used as required, as well as asking the chef. Dining Services Manager and/or designee will do checks of eggs to ensure that staff are preparing the correct eggs in the manner required. Checks will be completed 2 times per week x 2 weeks, then 1 time per week x 4 weeks to ensure Food Preparation compliance. Audit form will be completed.

	Audits will be reviewed during monthly QA Meetings; QA Committee will determine if continued auditing is necessary based on compliance from the audits. Monitoring records will be kept in the office of the Executive Director in the Plan of Corrections Binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Lisa Sanders, ED** Lisa Sanders, ED OAC 310:663-25-4(F)	**Date 7/3/2023**

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: 6/30/2023** **Facility Name:** The Gardens at Quail Springs (formerly Villagio) **License Number:** AL5514 **Survey Event ID:** SGY811 **Date Survey Completed: 6/6/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C542	Based on: Record review and interview, the facility failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's personal physician for 10 (#1, 2, 3, 4, 5, 6, 7, 8, 9 and 10) of ten sampled residents whose assessments were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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?	The Wellness Director and Registered Nurse have completed Comprehensive Assessments on residents #1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 with a personal interview conducted between the resident and/or the resident's representative. These Assessments were completed, coordinated and signed by a Registered Nurse or the resident's physician. These were completed and signed on or before July 3, 2023.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents have the potential to be affected by the alleged deficient practice.
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 Wellness Director, licensed designee and/or Registered Nurse will ensure that comprehensive assessments contain a signature to indicate a personal interview has been conducted between the resident or the resident's representative. These assessments are completed, coordinated and signed by a Registered Nurse or the resident's Physician on all current residents and every new admission. The Wellness Director and Executive Director were inserviced on 6/30/2023 by Dena Davis, RN on the requirement for the assisted living center to ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1)

	of the persons listed in (d)(2) and (d)(3) of section 310.663-5-4 (c).
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.	The Wellness Director, licensed designee and/or Registered Nurse will be responsible for sustained compliance. The Wellness Director, licensed designee and/or Registered Nurse will do random audits of 4 resident Comprehensive Assessments for signature of the Registered Nurse or Physician 2 times a week for 2 weeks, then 2 random residents a week for 2 weeks then 1 random resident a week for 2 weeks. Audits will be reviewed during monthly QA Meetings; QA committee will determine if continued auditing is necessary based on compliance from audits. Monitoring records will be kept in the office of the Executive Director in the Plan of Corrections Binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Lisa Sanders, ED Lisa Sanders, ED OAC 310:663-25-4(F)	**Date 7/3/2023**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/30/2023** **Facility Name:** The Gardens at Quail Springs (formerly Villagio) **License Number:** AL5514 **Survey Event ID:** SGY811 **Date Survey Completed: 6/6/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C544	Based on: Record review and interview, the facility failed to maintain all resident assessments for five years, for five (#1, 2, 7, 8, and #10) of 10 residents reviewed for resident assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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?	New company took over on 4/3/2023 and discovered documentation was not stored or kept correctly for 7 years nor did they follow regulatory. Prior company has no further documentation to offer. Going forward, resident files with assessments will be securely retained according to regulations and company policies.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents have the potential to be affected by the alleged deficient practice.
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 Wellness Director and/or licensed designee will ensure that resident assessments are maintained for five (5) years from the date of the assessment, as well as all resident files in a secured area for at least seven (7) years from discharge of the facility. The Wellness Director and Executive Director were inserviced on 6/30/2023 by Dena Davis, RN on these requirements.
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.	The Wellness Director, licensed designee and/or Registered Nurse will be responsible for sustained compliance. The Wellness Director or licensed designee will do random audits of 4 current and/or past resident files to ensure that the Comprehensive Assessments are present in the file 2 times a week for 2 weeks, then 2 random residents a week for 2 weeks then 1 random resident a week for 2 weeks.

	Audits will be reviewed during monthly QA Meetings; QA committee will determine if continued auditing is necessary based on compliance from audits. Monitoring records will be kept in the office of the Executive Director in the Plan of Corrections Binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Lisa Sanders, ED Lisa Sanders, ED OAC 310:663-25-4(F)	**Date 7/3/2023**

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

OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@gardensatquailsprings.com

September 11, 2023

License Number: AL5514

Ms. Lisa Sanders, Administrator/Executive Director
Villagio Of Oklahoma City
14300 North Portland
Oklahoma City, OK 73134

RE: Survey Event SGY812

Dear Ms. Sanders:

On **September 11, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 6, 2023,** have now been corrected effective **August 30, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5514	A. BUILDING: _____ B. WING _____	R-C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGIO OF OKLAHOMA CITY	14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134

(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 09/11/23. 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