OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@gardensatquailsprings.com

January 29, 2024

License Number: AL5514

Ms. Lisa Sanders, Executive Director
The Gardens at Quail Springs Assisted and Memory
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: 6TOG11

Dear Ms. Sanders:

On **January 12, 2024,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your assisted living facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on 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 will be completed for each violation; and
(6) Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 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 a 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,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: THE GARDENS AT QUAIL SPRINGS ASSISTED AND MEMORY
Address: 14300 NORTH PORTLAND
City, State, Zip: OKLAHOMA CITY, OK 73134
Provider #: AL5514
Complaint #: OK00058927
Investigation Dates: 01/09/24 through 01/12/24

ALLEGATIONS

The center failed to ensure resident safety related to falls.
The center failed to ensure staff were treated with dignity and respect.
The center failed to ensure a clean/comfortable/homelike environment.

An unannounced on-site investigation was initiated 01/09/2024 at 1:19 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Resident rooms, bathrooms, and hallways were observed for cleanliness. Staff interactions with residents were observed. Residents and resident rooms were observed for falls and fall precautions.

Facility policies and procedures were reviewed. **Resident assessments, nurses' notes, physician orders, and** hospital records were reviewed. State reportables were reviewed.

Residents and resident representatives were interviewed regarding staff interactions with them, falls, and clean homelike environment. Staff were interviewed regarding the facility policies and procedures related to dignity and respect, falls, and clean homelike environment.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health

Long Term Care Service

Date report completed: 01/12/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: THE GARDENS AT QUAIL SPRINGS ASSISTED AND MEMORY
Address: 14300 NORTH PORTLAND
City, State, Zip: OKLAHOMA CITY, OK 73134
Provider #: AL5514
Complaint #: OK00061089
Investigation Dates: 01/09/24 through 01/12/24

ALLEGATIONS

The facility failed to ensure residents received assistance with activities of daily living in a safe, timely manner.
The facility failed to ensure new nursing staff were trained according to the standard of care.

An unannounced on-site investigation was initiated 01/09/2024 at 1:19 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Residents were observed for activities of daily living and staff competence during the provision of care.

Facility policies and procedures were reviewed. Resident assessments, nurses' notes, and physician orders were reviewed. Staff training and in-services were reviewed.

Residents and resident representatives were interviewed regarding activities of daily living and whether staff were qualified to care for them. Staff were interviewed regarding the facility policies and procedures related to providing activities of daily living in a timely manner and the training they received for their roles.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health

Long Term Care Service

Date report completed: 01/12/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: THE GARDENS AT QUAIL SPRINGS ASSISTED AND MEMORY
Address: 14300 NORTH PORTLAND
City, State, Zip: OKLAHOMA CITY, OK 73134
Provider #: AL5514
Complaint #: OK00061322
Investigation Dates: 01/09/24 through 01/12/24

ALLEGATIONS

The center failed to ensure residents were not physically, verbally or psychosocially abused.
The facility failed to ensure residents received adequate meal portions, physician ordered diets, snacks and were not left hungry after meals.
The center failed to provide ADL assistance to dependent residents, i.e., brushing teeth, showering, personal hygiene, and failed to ensure residents' clothes were laundered in a timely manner.
The center failed to ensure adequate staff to provide care for dependent residents.

An unannounced on-site investigation was initiated 01/09/2024 at 1:19 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various shifts throughout the survey. Staff and resident interactions were observed. Meal service was observed. Staff were observed during activities of daily living and laundry services. The number of staff on the units were observed.

Facility policies and procedures were reviewed. Resident assessments, nurses' notes, and physician orders were reviewed. State reportables were reviewed. Staff schedules were reviewed.

Residents were interviewed regarding staff interactions with them. Residents were interviewed regarding snacks, meals, diet, activities of daily living, laundry, and adequate staff to care for their needs. Staff were interviewed regarding the facility policies and procedures related to abuse, activities of daily living, adequate staffing, meal services and snacks.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/12/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: THE GARDENS AT QUAIL SPRINGS ASSISTED AND MEMORY
Address: 14300 NORTH PORTLAND
City, State, Zip: OKLAHOMA CITY, OK 73134
Provider #: AL5514
Complaint #: OK00061397
Investigation Dates: 01/09/24 through 01/12/24

ALLEGATIONS

The center failed to ensure adequate, competent staff to carry out the duties in the kitchen and failed to ensure snacks were provided according to the plan of care and residents' preference.
The center failed to ensure a clean, sanitary and homelike environment.
The center failed to ensure medical records were not falsified.

An unannounced on-site investigation was initiated 01/09/2024 at 1:19 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various shifts throughout the survey. Kitchen staff were observed, available snacks were observed. Resident rooms and hallways were observed for cleanliness and leaks.

Facility policies and procedures were reviewed. Resident assessments, nurses' notes, and physician orders were reviewed and compared. Employee records were reviewed.

Residents were interviewed regarding snacks, clean, sanitary, and homelike environment, and adequate staff to care for their needs. Staff were interviewed regarding the facility policies and procedures related to adequate staffing, falsification of medical records, snacks, and competent staff.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/12/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: THE GARDENS AT QUAIL SPRINGS ASSISTED AND MEMORY
Address: 14300 NORTH PORTLAND
City, State, Zip: OKLAHOMA CITY, OK 73134
Provider #: AL5514
Complaint #: OK00062046
Investigation Dates: 01/09/24 through 01/12/24

ALLEGATIONS

The center failed to assess, monitor and intervene in a timely manner for a change in condition.
The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 01/09/2024 at 1:19 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various shifts throughout the survey. Residents were observed for change in condition. The number of staff on the units were observed.

Facility policies and procedures were reviewed. Resident assessments, nurses' notes, and physician orders were reviewed. Staff schedules were reviewed.

Residents were interviewed regarding a change in condition and adequate staffing. Staff were interviewed regarding the facility policies and procedures related to a change in condition and adequate staffing.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/12/2024

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 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT QUAIL SPRINGS ASSISTED AND M	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 Complaint investigations (#OK00058927, OK00061089, OK00061322, OK00061397, and #OK00062046) were conducted on 01/09/24 and 01/12/24. Facility Census: 67 The following abbreviations will be used throughout this document. LPN- license practical nurse MAR- medication administration record MG- milligram ML-milliliters	C 000		
C 522 SS=D	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 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 complete a comprehensive assessment for one (#5) of nine sampled residents whose assessments were reviewed. The Administrator identified 67 residents resided in the center.	C 522		

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 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT QUAIL SPRINGS ASSISTED AND M	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 522	Continued From page 1 Findings: Resident #5 was admitted on 04/11/22 and had diagnoses which included multiple sclerosis, seizures, and psychosis. A review of Resident #5's clinical record documented the last comprehensive assessment was completed on 09/02/22. On 01/11/24 at 3:01 p.m., the Administrator stated they could not locate the comprehensive assessment for Resident #5.	C 522		
C1921 SS=E	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on record review and interview, the center failed to administer medication according to the physician's order for one (#3) of three sampled residents reviewed for assessing, monitoring, and intervening in a change in condition. The Administrator identified 67 residents resided in the center. Findings: Resident #3 had diagnoses which included Covid-19, end stage renal disease and	C1921		

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 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT QUAIL SPRINGS ASSISTED AND M	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
C1921	Continued From page 2 congestive heart failure. A physician's order, dated 12/16/23, documented azithromycin 250 mg give one tablet by mouth daily for four days diagnosis covid-19. A physician's order, dated 12/16/23, documented delsym cough/chest congestion oral liquid 5-100 mg per 5 ml give 30 ml by mouth every 12 hours routine for 10 days diagnosis. On 01/09/24 at 4:06 p.m., Resident #3 stated they did not receive their medication for cough and Covid-19 when they tested positive Covid-19. A review of Resident #3's December 2023 MAR documented; a. azithromycin 250 mg with notation N/A on 12/16/23 and 12/17/23, b. delsym oral liquid 5-100 mg per 5 ml with notation med not here on 12/23/23 and 12/24/23 for both doses, and c. delsym oral liquid 5-100 mg per 5 ml with notation N/A on 12/25/23, 12/26/23, and 12/27/23. On 01/11/24 at 11:14 a.m., LPN #1 reviewed Resident #3's MAR. They stated Resident #3 did not receive azithromycin for the two out of four days scheduled. On 01/11/24 at 11:16 a.m., LPN #1 stated Resident #3 did not receive delsym on the days listed above. LPN #1 stated they did not know what N/A meant on the administration notes.	C1921		
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in	C1972		

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 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT QUAIL SPRINGS ASSISTED AND M	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
C1972	Continued From page 3 the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were educated on abuse within 90 days of hire for one (Dietary aide #1) of eight employees whose records were reviewed. The Administrator identified 67 residents resided in the center. Findings: Dietary aide #1 was hired on 05/08/23 and had no documentation of abuse training. On 01/11/24 at 3:37 p.m., the Administrator stated they could not locate abuse training for Dietary aide #1. They stated it should have been done upon hire.	C1972		

OKLAHOMA
State Department
of Health

Delivery via email to: Sarah Martin <executivedirector@gardensatquailsprings.com>

February 13, 2024

License Number: AL5514

Sarah Martin, Executive Director
The Gardens At Quail Springs Assisted And Memory
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: 6TOG11

Dear Ms. Martin:

On **January 12, 2024,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **March 4, 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/28/2024** **Facility Name:** The Gardens at Quail Springs **License Number:** AL5514 **Survey Event ID:** 6TOG11 **Date Survey Completed: 1/12/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522	Based on: record review and interview, the center failed to complete a comprehensive assessment for one (#5) of nine 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?	An up to date comprehensive assessment was complete with all required signatures for resident #5.
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 require comprehensive assessments, therefore all residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Licensed nursing staff will be in-serviced on assessment timeframes and 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.	Audits will be conducted be the administrator/designee to ensure assessments are completed within the required timeframe and with the required signatures. Audits will by conducted weekly x 1 month, then monthly x 2 months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/4/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Sarah Martin, ED** OAC 310:663-25-4(F)	**Date 2/8/2024**

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: 2/8/2024** **Facility Name:** The Gardens at Quail Springs **License Number:** AL5514 **Survey Event ID:** 6TOG11 **Date Survey Completed: 1/12/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1921	Based on: record review and interview, the center failed to administer medication according to the physician's order for one (#3) of three sampled residents reviewed for assessing, monitoring, and intervening in a change in condition.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn their from. The POC is intended to constitute the facility's written allegation of continued compliance.

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 physician's orders for identified resident #3 were reviewed with nursing staff to ensure medication administration and timeliness as ordered.
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 physician's orders have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All licensed nurses and medication aides will be in-serviced on medication administration, and timeliness as ordered.
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.	Audits will be conducted be the administrator/designee to ensure medication administration, and timeliness as ordered. Audits will by conducted weekly x 1 month, then monthly x 2 months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/4/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Sarah Martin, ED** OAC 310:663-25-4(F)	**Date 2/8/2024**

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: 2/8/2024** **Facility Name:** The Gardens at Quail Springs **License Number:** AL5514 **Survey Event ID:** 6TOG11 **Date Survey Completed: 1/12/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1972	Based on: record review and interview, the center failed to ensure staff were educated on abuse within 90 days of hire for one (Dietary aide #1) of eight employees whose records were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn their from. The POC is intended to constitute the facility's written allegation of continued compliance.

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 identified employee, dietary aide #1 was trained on abuse, neglect and misappropriation of resident property. Verification of training was signed and placed in employee's personell file.
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 employees who require training on abuse, neglect, and misappropriation of resident property have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All managers in-serviced on requirement for staff training on abuse, neglect and misappropriation of property.
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.	Audits will be conducted be the administrator/designee to ensure medication administration, and timeliness as ordered. Audits will by conducted weekly x 1 month, then monthly x 2 months Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/4/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Sarah Martin, ED** OAC 310:663-25-4(F)	**Date 2/8/2024**

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.			