
Delivery via email to: ed@thegardensqs.com

April 15, 2025

License Number: AL5514

Ms. Sarah Martin, Administrator
The Gardens at Quail Springs Assisted And Memory
14300 North Portland
Oklahoma City, OK 73134

RE: Survey Event ID: XKG811

Dear Ms. Martin:

On **April 4, 2025**, agents from our office concluded a State Licensure survey 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 **April 4, 2025**.

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 part of the 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: IDRCoordinator@health.ok.gov

Or mail 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

INVESTIGATIVE REPORT

Facility: The Gardens at Quail Springs
Address: 14300 North Portland Ave
City, State, Zip: Oklahoma City, OK 73134
Provider #: AL5514
Complaint #: OK00074999
Investigation Date(s): 04/03/25-04/04/25

ALLEGATION(S)
The facility failed to ensure care was provided to residents who were dependent on staff for ADL's
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 04/03/2025 at 8:30 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation: Residents were observed for soiled garments and frequency of ADLs provided by staff. Staff and family were interviewed regarding ADLs provided to residents. Records reviewed for residents included contracts of services provided, service plans, and comprehensive assessments. Based on observation, record review, and interview, the center provided ADLs per regulations and resident needs.

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: 04/04/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/04/2025
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT QUAIL SPRINGS ASSISTED AND N		STREET ADDRESS, CITY, STATE, ZIP CODE 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 relicensure survey was conducted from 04/03/25 through 04/04/25. A complaint investigation (#OK00074999) was conducted in conjunction with the survey. Deficiencies were cited as a result of the survey and complaint investigation. Facility Census: 65	C 000		
C2700 SS=F	310:663-27-1 APPLICATION FORM CHANGES Any substantial change in the information originally reported in the license application shall be submitted to the Department for review. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure substantial changes to the application had been made to the department. The director of nursing identified 65 residents resided in the center. Findings: On 04/03/25 at 1:30 p.m. the Oklahoma State Health Department Health Resources verified the administrator on record with the Department. On 04/03/25 at 1:43 p.m., the administrator's license with an expiration date of 12/31/25 was hanging on the wall in the front hallway. The administrator's license did not match the administrator on record with the Department. On 04/03/25 at 1:44 p.m., the director of nursing was asked who the current administrator was. The director of nursing replied with the name	C2700		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/04/2025
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C2700	Continued From page 1 matching the administrator's license hanging on the wall, which did not match the administrator on record with the Department. The director of nursing was asked when the current administrator was hired for the center and they stated, "January 30, 2024." When asked if a notification of change was submitted to the Department, the director of nursing stated, "The previous management company is looking for it." On 04/04/25 at 10:00 a.m. the director of nursing was asked if the notification of change form regarding change of administrators had been located. They replied, "No."	C2700		

Delivery via email to: Ed@thegardensqs.com

April 28, 2025

License Number: AL5514

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

RE: Survey Event XKG811

Dear Ms. Martin:

On **April 4, 2025**, a Licensure inspection with a complaint investigation was conducted at your Assisted Living Center facility. 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 in a timely manner. **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 **April 29, 2025**.

We will conduct a revisit 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: 4/25/2025

Facility Name: The Gardens at Quail Springs

License Number: AL5541

Survey Event ID: XKG811

Date Survey Completed: 4/4/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C2700

Based on: record review and interview, the center failed to ensure substantial changes to the application had been made to the department.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

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

ED will submit ODH form 958 to the Dept by 5/2/25

All residents who reside at the community have the potential to be affected.

ED & regional operations specialist will be in-serviced on regulations r/t reporting application & licensure reporting requirements.

Audits will be conducted by the administrator/regional operations specialist/designee to ensure timely compliance as required.

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 QA binder and the POC binder as evidence of the correction.

Enter methods to keep monitoring records:

Administrator's Signature Sarah Martin

OAC 310:663-25-4(F)

Date 4/28/2025

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.](#)

Delivery via email to: Ed@thegardensqs.com

May 7, 2025

License Number: AL5514

Ms. Sarah Martin, Administrator
The Gardens at Quail Springs Assisted and Memory
14300 North Portland
Oklahoma City, OK 73134

RE: Survey Event XKG812

Dear Ms. Martin:

On **May 5, 2025**, an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **April 4, 2025**, have now been corrected effective **April 29, 2025**.

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 05/05/2025
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT QUAIL SPRINGS ASSISTED AND N		STREET ADDRESS, CITY, STATE, ZIP CODE 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 05/05/25. 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