Delivery via email to: Ed@thegardensqs.com

July 16, 2025

License Number: AL5514

Ms. Jennifer Beagle, Administrator
The Gardens At Quail Springs Assisted and Memory
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: E13011

Dear Ms. Beagle:

On **July 8, 2025**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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. 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 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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: The Gardens at Quail Springs
Address: 14300 North Portland
City, State, Zip: OKC, OK 73134
Provider #: AL 5514
Complaint #: OK00082037
Investigation Date(s): 07/07-07/08/25

ALLEGATION(S)
The center failed to ensure food was served at the preferred temperature
The center failed to ensure call lights were answered in a timely manner
The center failed to ensure the right to choose the time to get out of bed
enter text
enter text

An unannounced on-site investigation was initiated 07/07/2025 at 6:30 a.m.

A sample of 9 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: Observations of the kitchen, food temperatures and residents were made. Records of resident service plans, assessments, kitchen and food policies were reviewed. Interviews were conducted with residents, families, and staff. Based on observations, record reviews, and interviews it was determined the center is in compliance with state regulations.

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: 07/08/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: The Gardens at Quail Springs
Address: 14300 North Portland
City, State, Zip: OKC, OK 73134
Provider #: AL 5514
Complaint #: OK00083843
Investigation Date(s): 07/07-07/08/25

ALLEGATION(S)
The facility failed to provide adequate supervision to prevent an elopement
enter text
enter text

An unannounced on-site investigation was initiated 07/07/2025 at 6:30 a.m.

A sample of 9 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: Observations of residents and staff were made. Interviews with residents, staff, families, and a physician's assistant were conducted. Records including residents' health charts, assessments, physician notes, and policies were reviewed. Based on observations, record reviews, and interviews, it was determined the center failed to prevent an elopement.

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: 07/08/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: The Gardens at Quail Springs
Address: 14300 North Portland
City, State, Zip: OKC, OK 73134
Provider #: AL 5514
Complaint #: OK00083848
Investigation Date(s): 07/07-07/08/25

ALLEGATION(S)
The facility failed to follow infection control policies and procedures.
enter text
enter text

An unannounced on-site investigation was initiated 07/07/2025 at 6:30 a.m.

A sample of 9 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: Observations of glove use, cleanliness, and the presence of animals were made. No animals were found in the center. Records of policies were reviewed. Interviews with staff, residents, and families were conducted. Based on observation, record review, and interview the center follows sufficient infection control guidelines.

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: 07/08/2025

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 07/08/2025

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 A complaint investigation (#OK00082037, OK00083843, and #OK00083848) was conducted on 07/07/25 through 07/08/25. Facility census: 68 The following is a list of abbreviations that will be used throughout this document. ADON- assistant director of nursing CNA- certified nurse's aide CMA- certified medication aide DON- director of nursing IJ- immediate jeopardy OSDH- Oklahoma State Department of Health PRN - as needed	C 000		
C1512 SS=K	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under	C1512		

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C1512	Continued From page 1 the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by:	C1512		

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C1512	Continued From page 2 On 07/07/25, an IJ situation was determined to exist when the center failed to provide supervision and intervene for Residents #1 and #2 to prevent elopement. On 07/07/25 at 1:02 p.m., the OSDH was notified and verified the existence of the IJ situation. On 07/07/25 at 1:11 p.m., the administrator, DON, and ADON were notified of the IJ situation related to the elopement of Residents #1 and #2. On 07/07/25 at 8:30 p.m., the administrator submitted an acceptable plan of removal. The plan of removal read in part, "Plan of Removal - IJ Tag Facility: The Gardens at Quail Springs State: Oklahoma Date of Completion: By 3:00 PM on 7/8/2025 To immediately address and eliminate the cited Immediate Jeopardy, the following corrective steps will be fully implemented within 24 hours: Staff Inservice on Elopement Policy: o All staff will receive an in-person in-service regarding the Surpass elopement policy. o Staff not on site will be contacted by phone, with documentation of the call and a request for verbal or written acknowledgment of receipt. o Staff unreachable after three (3) documented contact attempts will not be permitted to begin a shift until elopement policy documentation is received and verified. Resident Risk Identification & Communication: o All residents residing in Memory Care will be reassessed for an elopement risk by 3pm, 7/8/25. Those residents with the identified Risk Status of: 'At Risk To Wander From the Facility'	C1512		

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C1512	Continued From page 3	C1512		

and 'At Risk To Elope From the Facility' will have their face sheet with photo added to the Elopement binder located at the nurse station.

o A condensed list with resident name and room number will be placed and maintained in the front cover of the binder.

o Staff will be informed of the binder with the updated list as part of the in-service.

o All Assisted Living residents will have a current elopement risk assessment by 7/21/2025. Those identified to be 'At Risk' will have their face sheet with photo placed in an Elopement binder at the AL nurse station. A condensed list will be placed and maintained in the front cover of the binder.

Physician Statements for Residents Who Eloped:

o Signed physician statements per policy will be obtained for both residents involved in the 6/21/2025 elopement and placed in their records by 3:00 PM on 7/8/2025.

Ongoing Compliance for Physician Statements:

o Signed physician statements for all current residents with dementia will be obtained by July 21, 2025.

o For all new residents, physician statements will be obtained within 14 days of admission, and filed with the resident's service plan as part of admission protocol."

The IJ was removed on 07/08/25 at 3:00 p.m., when all components of the plan of removal had been verified as completed. On 07/08/25 at 3:05 p.m., and observation was made of an "Elopement Risk Binder," at the memory care nurse's stations. Interviews conducted with staff verified staff had been given an in-service on the center's "Elopement Policy," residents who are at an increased risk of elopement, educated on the

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center's "Elopement Risk Binder," and how to prevent elopements on 07/07/25. Records reviewed verified all memory care residents were re-assessed for elopement risk, an "Elopement Risk Binder," was created with face sheets and photos of residents who were at a higher risk of elopement, and a physician statement for Residents #1 and #2 were obtained and signed by their attending physician. The deficiency remained at a pattern level with a potential for more than minimal harm.

Based on observation, record review, and interview, the facility failed to provide supervision to prevent an elopement for 2 (#1 and #2) of 4 sampled residents reviewed for elopement.

The DON identified 25 residents resided in the memory care unit.

Findings:

On 07/07/25 at 7:01 a.m., Resident #1 was observed in the memory care dining room sitting in front of the television.

On 07/07/25 at 7:15 a.m., Resident #2 was observed lying in bed in their apartment.

On 07/07/25 at 10:00 a.m., both Residents #1 and #2 were observed sitting in the memory care common area talking with staff and each other. There were no exit seeking behaviors observed.

On 07/07/25 at 11:07 a.m., both Residents #1 and #2 were observed engaging in activities in the memory care common area with staff.

A policy titled "Clinical09- Elopement," dated 06/10/20, read in part, "Residents will be

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screened prior to admission for significant elopement risk. If the resident has a diagnosis of dementia or a history of elopement, a physician's statement regarding leaving the building unescorted will be obtained. Should an elopement occur the resident will be re-evaluated to determine if the resident is appropriate to be retained in the Community."

1. A document from a hospital titled "Medicine Consult," dated 03/22/25, read in part, "[Resident #1] attempted self harm by OD [over dose]. Mild vascular dementia with mood disturbances."

A "14-day Comprehensive Assessment," dated 04/10/25, showed Resident #1 was admitted to the facility on 04/10/25 with diagnoses to include major neurocognitive disorder with behavioral disturbance and major depressive disorder. The "14-day Comprehensive Assessment," showed Resident #1 was confused at times and forgetful.

2. A document from a hospital titled, "History and Physical," dated 05/05/25, read in part, "[Resident #2] presents to [name-deleted emergency department] via [name-deleted police department]. [name deleted police officer] states "We received a call from [Resident #2's] neighbor that they witnessed [Resident #2] stabbing/killing [their] dog and buried her in the backyard. He had no memory of anything happening and did not know what day it was or the time of day."

A "14-day Comprehensive Assessment," dated 05/15/25, showed Resident #2 was admitted to the facility on 05/15/25 with diagnoses to include dementia and aggression.

On 06/21/25, OSDH received an incident report. The incident report, read in part, "At approx

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[approximately] 6:30 p.m. the fire alarms went off. Staff initiated fire safety rounds. Upon starting a head count of resident's, It was determined that the fire alarm was triggered by one of the memory care residents. Call received from [name deleted police department] during fire safety rounds, that residents were next door at the [name deleted hospital]. Staff went next door and brought residents back to the community. Q2hr [every 2 hour] checks were initiated x72hrs [for 72 hours]." The ADON identified the residents referenced in this incident report to be Residents #1 and #2.

An undated document titled "The Gardens Assisted Living and Memory Care Observations," showed Residents #1 and #2 were observed post elopement every two hours for 72 hours from 06/21/25 through 06/23/25 and no exit seeking behaviors were reported.

On 07/07/25 at 6:53 a.m., CNA #5 was asked their knowledge of residents eloping from the memory care unit recently. They stated, "I was just hired last week, I don't know anything about elopements."

On 07/07/25 at 6:55 a.m., CNA #2 was asked their knowledge of residents eloping from the memory care unit recently. They stated, "I just work PRN. I don't know anything about that."

On 07/07/25 at 7:02 a.m., Resident #1 was asked if they recalled any fire alarms in the memory care unit lately. They stated, "No, not at all." Resident #1 was asked if they go for walks outside while living here. They stated,"Yeah, a few. I went on one about 3 weeks ago." Resident #1 was asked where they were going . They stated, "Anywhere but here." Resident #1 was asked where they went on their walk. They

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stated, "Me and another guy went to a building and then we were brought back here."

On 07/07/25 at 7:07 a.m., CMA #4 was asked what Resident #1's demeanor was like. They stated, "Calm, usually, but they get agitated about being here." CMA #4 was asked to tell about Residents #1 and #2 eloping. CMA #4 stated, "Oh, I didn't know that happened." CMA #4 was asked if they had any recent in-service education regarding resident elopement. They stated, "No."

On 07/07/25 at 7:09 a.m., CMA #4 was asked what Resident #2's demeanor was like. They stated, "[Resident #2] doesn't exit seek, but would follow someone. [Resident #2] joined another resident who was exit seeking one time." CMA #4 was asked if Resident #1 exit seeked. They stated, "[Resident #2] will verbally ask to be let out." CMA #4 was asked if Resident #1 goes to the doors to try getting out. They stated, "About 2 to 3 times a week." CMA #4 was asked how often they check on the memory care residents. They stated, "Every two hours, but usually one of us are always with them."

On 07/07/25 at 7:15 a.m., Resident #2 was asked if they recalled any fire alarms in the memory care unit lately. They stated, "No." Resident #2 was asked if they go for walks outside. They stated, "Oh yeah, around the perimeter." Resident #2 was asked if they go alone or with someone. They stated, "Alone." Resident #2 was asked if they walked to any buildings nearby or any hospitals. They stated, "Not to my knowledge."

On 07/07/25 at 7:19 a.m., CMA #5 was asked what they knew about Residents #1 and #2 eloping. They stated, "I just heard they got out. I didn't ask any questions." CMA #5 was asked

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how they heard the residents eloped and they stated, "Another staff member who wasn't here at the time so they didn't know much."

On 07/07/25 at 7:26 a.m., CNA #3 was asked what they knew about Residents #1 and #2 eloping. They stated, "I don't know anything except another staff member, I can't remember who, told me to keep an eye on them because they got out." CNA #3 was asked if they had any in-service education on elopements. CNA #3 stated, "6 months to a year ago."

On 07/07/25 at 7:30 a.m., CMA #3 was asked if there had been any residents elope out of the center recently. They stated, "No."

On 07/07/25 at 9:29 a.m., Resident #2's family member was asked what they knew about Resident #2's elopement. They stated, "An officer called it into [name-deleted city] police dispatch because that's the address on his license. I work there and confirmed it was my [family member]." Resident #2's family member stated they were told the resident and their friend from the memory care unit exited the building when the fire alarm was triggered and went for a walk. They denied having any concerns about the center or Resident #2's care.

On 07/07/25 at 10:43 a.m., the DON was asked what interventions were put into place for Residents #1 and #2 post elopement. They stated, "Immediate in-service for those working that weekend. The next in service will include the entire staff for elopement. Also, the every 2 hour checks." They were asked when the next in-service would be. They stated, "July 17th or 18th." Copies of the every two hour checks were requested.

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 07/08/2025

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
C1512	Continued From page 9 On 07/07/25 at 10:50 a.m., CMA #1 was asked what their knowledge was regarding Residents #1 and #2 elopements. They stated, "The fire alarm was set off. I work on the assisted living side. Two memory care gentlemen got out and they were across the street in the parking lot of [name-deleted hospital]." CMA #1 was asked what interventions were put into place post elopement. They stated, "Same day in-service about fire alarms and elopement." They were asked what interventions were put into place to prevent future elopements of the residents. They stated, "I do not know for sure." On 07/07/25 at 11:29 a.m., the ADON was asked how residents were identified as an elopement risk. They stated, "It's the ones who try to get out." On 07/07/25 at 11:31 a.m., the DON was asked if elopement risk assessments were conducted pre-admission or on admission. They stated, "We do not do either." The DON was asked if Residents #1 and #2 were assessed for elopement risk post elopement. They stated, "Yes." On 07/07/25 at 11:57 a.m., CNA #1 was asked which memory care residents were at a higher risk for elopement. They named unidentified residents and Resident #1. CNA #1 did not include Resident #2. CNA #1 was asked how they knew who was at a higher risk for elopement. They stated, "It's just what I've seen." CNA #1 denied having any education or lists regarding residents identified as having a higher risk of elopement. On 07/07/25 at 12:05 p.m., Physician #1	C1512		

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	AL5514	A. BUILDING: _____ B. WING _____	C 07/08/2025

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THE GARDENS AT QUAIL SPRINGS ASSISTED AND M	14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134

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C1512	Continued From page 10	C1512		

approached this surveyor and stated they were seeing Residents #1 and #2 today. They stated, "Neither were showing behaviors prior to the elopement and their meds [medicines] were adjusted appropriately." Physician #1 was asked when the center called them to come see Residents #1 and #2. They stated, "I wasn't notified of this incident (elopement) until today when I came in to see [Resident #2] and I added [Resident #1] because of it." Physician #1 reported both residents were stable at last report and they have only seen Residents #1 and #2 one time prior to the elopement.

On 07/08/25 at 3:02 p.m., the ADON approached and stated two employees could not be reached for in-service regarding elopement. They stated, "They will not be allowed back on shift until in-service is completed."

On 07/08/25 at 3:15 p.m., CNA #6 was asked what was the center's elopement policy. They stated, "If a resident gets out we are to look for them immediately and notify our administrator or nurse." CNA #6 was asked if law enforcement was called at any point. CNA #6 stated, "If they're not found within 30 minutes of searching the building." CNA #6 was asked how they prevented an elopement. CNA #6 stated, "We check on residents every two hours, especially the ones who try to get out." CNA #6 was asked which residents were a higher elopement risk. They stated Residents #1 and #2. CNA #6 stated, "We have a binder at the nurse's station with their names." CNA #6 was asked when they were last educated or given an in-service on elopements. They stated, "Yesterday."

On 07/08/25 at 3:21 p.m., CNA #1 was asked what was the center's elopement policy. They

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C1512	Continued From page 11 stated, "We try to keep residents from getting out by laying eyes on them frequently. If they do get out we call our supervisor while searching for them." CNA #1 was asked which residents were a higher elopement risk. They stated Residents #1 and #2 and pointed at the elopement risk binder, "This tells us who all might try to get out." CNA #1 was asked when they were last educated or provided an in-service on elopement. They stated, "Yesterday."	C1512		

OKLAHOMA
State Department of Health

Delivery via email to: Ed@thegardensqs.com

July 30, 2025

License Number: AL5514

Ms. Jennifer Beagle, Administrator
The Gardens At Quail Springs Assisted And Memory
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: E13011

Dear Ms. Beagle:

On **July 8, 2025,** 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 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 during that survey have been corrected and you were in substantial compliance by **July 24, 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: 7/23/2025** **Facility Name:** The Gardens at Quail Springs **License Number:** AL5514 **Survey Event ID:** E13011 **Date Survey Completed: 7/8/2025**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1512plan	Based on: observation, record review, and interview, the facility failed to provide supervision to prevent an elopement for 2 (#1 and #2) of 4 sampled residents reviewed for elopement.
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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All staff have received an in-service regarding the Surpass elopement policy. All residents residing in Memory Care have been reassessed for an elopement risk. Those residents with the identified Risk Status of: 'At Risk To Wander From the Facility' and 'At Risk To Elope From the Facility' have had their face sheet with photo added to the Elopement binder located at the nurse station. A condensed list with resident name and room number have been placed and maintained in the front of the binder. Staff have been informed of the binder with the updated list as part of the in-service. All Assisted Living residents will have a current elopement risk assessment. Those identified to be 'At Risk' will have their face sheet with photo placed in an Elopement binder at the AL nurse station. A condensed list will be placed and maintained in the front of the binder. Signed physician statements per policy have been obtained for both residents involved in the 6/21/2025 elopement and placed in their records. Signed physician statements for all current residents with dementia will be obtained. For all new residents, physician statements will be obtained within 14 days of admission, and filed with the resident's service plan as part of admission protocol.
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 a diagnosis of dementia or history of elopements 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 responsible for training and/or overseeing direct care staff have been in-servied on Surpass elopement policy. All direct care staff has also been in-serviced on elopement policy. Enter method to ensure corrections are sustained

OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: Audits will be conducted by the administrator/DON/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.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/24/2025
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Jennifer Beasley	**Date** Enter a date of Signature. 7/28/2025

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.

OKLAHOMA
State Department of Health

FINAL DETERMINATION

USPS Tracking #9589 0710 5270 2318 8422 01

August 29, 2025

License Number: AL5514

Ms. Jennifer Beagle, Administrator
The Gardens At Quail Springs Assisted and Memory
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: E13012

Dear Ms. Beagle:

A revisit conducted on **August 25, 2025**, revealed that your facility corrected deficiencies effective **July 28, 2025**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

Respectfully,

Tempal Killman

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

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Oklahoma State Department of Health

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{C 000}	INITIAL COMMENTS A revisit was conducted on 08/25/25. All deficiencies from the 07/08/25 survey were cleared. Facility Census: 74	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE