



Oklahoma State Department of Health
Creating a State of Health

August 15, 2019

License Number: AL5523

Ms. Cheryl Seabaugh, Administrator
Quail Ridge Assisted Living Center
12401 Trail Oaks Drive
Oklahoma City, OK 73120

RE: Survey Event ID: BKIM11

Dear Ms. Seabaugh:

On **July 16, 2019**, 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 July 16, 2019.

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;

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- (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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

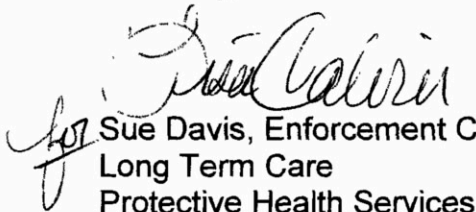
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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 IDRCordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,


Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lc

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Quail Ridge Assisted Living Center
Address: 12401 Trail Oaks Drive
City, State, Zip: Oklahoma City, OK, 73120
Provider #: AL 5523
Complaint #: OK00054001
Investigation Date(s): 07/08/19 through 07/11/19, and 07/15/19, and 07/16/19

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to provide services as contracted.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Monday, July 8, 2019 at 3:40 p.m.

A sample of 15 residents including any identified resident(s), 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to services provided to residents, to include housekeeping, pets, and safety, was conducted.

Observation made throughout the survey of the residents' apartments, hallways, and common areas indicated the center was regularly cleaned. There was no evidence of uncleanliness or foul odors identified in the hallways or common areas. No resident refused to have their apartment observed and only one apartment was found to have distinct odors of the dog that lived there with the residents. That apartment had three clean puppy pads by the sliding glass patio door, each time the apartment was observed, and no feces or urine was on any part of the floors. The same apartment had boxed and bagged belongings stacked along the bedroom wall, but there was a clear path from each side of the bed to the sliding glass patio door and into the living room. No

safety issue was determined in case evacuation was necessary. No evidence of pests was seen in any part of the center, and a pest control company was observed providing routine treatment.

Five residents were interviewed regarding services they receive, to include housekeeping, and all five stated they had no problems with anything and they complimented the employees. Five employees were interviewed about resident services provided and they all stated each resident received all the services offered in their contracts of direct care, medication administration, dietary, housekeeping of once a week, unless more often or if the resident refused, and laundry once a week. All five employees stated the residents in the apartment with the distinct dog odors had routinely refused to have their apartment cleaned, but they was working on a plan with housekeeping and other departments to better assist the residents.

A review of the 'Town Hall Meeting' notes did not document any problems with cleaning or odors. Resident contracts and the pet policy were reviewed and no problem was identified.

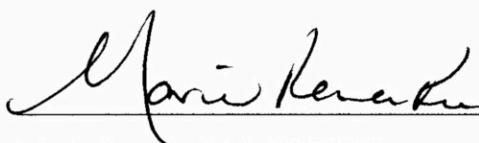
At the time of the investigation, there was no deficient practice related to housekeeping, pets, or safety.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script, appearing to read "Marie Remer", is written over a horizontal line.

Marie Remer, RN, CHFS IV

Date report completed: 07/24/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

QUAIL RIDGE SENIOR LIVING

**12401 TRAIL OAKS DRIVE
OKLAHOMA CITY, OK 73120**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A re-licensure survey was conducted on 07/08/19 through 07/11/19, 07/15/19, and 07/16/19. Complaint #OK00054001 was investigated in conjunction with the survey. Current census was 147. The following deficiencies were cited.	N 000		
N1105 SS=F	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure two hours of in-service training specific to their job duties were provided monthly for all long term care aides (LTCA) who provided direct resident care. This failed practice had the widespread potential for more than minimal harm for all 147 residents. Findings:	N1105		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N1105	Continued From page 1 On 07/16/19 at 11:15 a.m., the employees' in-service training records were reviewed and there was no start and stop times documented to determine the lengths of each in-service provided in January and February 2019. The center did not provide documentation of any in-services from March 2019 to June 2019. A human resources employee stated the former director of nursing had provided in-services but she did not know where the documentation was located. She also stated she did not know the time frames for the in-services provided in January and February 2019. POLICY An undated policy for training, orientation, and continuing education documented, "... All training and in-service needs will be conducted as designated by the community administrator...per individual state regulatory guidelines...each community shall be provided and shall maintain an in-service manual with a minimum of 12 in-service topics..."	N1105		
N1432 SS=E	310:677-13-7 (b) (7) (A) (B) (C) Skills And Functions Limitations. A certified medication aide shall not: (7) administer insulin unless a physician or licensed nurse is on-site if the individual: (A) Is newly diagnosed with diabetes; (B) Requires insulin administration based on blood glucose levels and does not have clear physician orders for variable or sliding scale insulin; or	N1432		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the center failed to ensure a physician or licensed nurse was on site when insulin was administered by certified medication aides with advanced training (CMA) to 1 (#8) of 1 sampled resident who required insulin administration for unstable diabetes. This failed

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N1432	Continued From page 3 practice had the potential for more than minimal harm at a pattern. Findings: Resident #8 had a diagnosis which included diabetes mellitus and was on short acting insulin per sliding scale and long acting insulin. The physician's orders documented to check the residents blood sugar before meals and administer insulin per sliding scale. Resident #8 had a hemoglobin A1c (blood test to measure average level of blood sugar over 2-3 months) level of 7.2 on 04/18/19. Resident #8's treatment administration record (TAR), dated 05/2019, documented her blood sugar was 197 on 05/03/19, 185 on 05/06/19 at 7:10 a.m., 228 at 11:00 a.m., 222 on 05/07/19 at 11:00 a.m., 266 on 05/08/19 at 11:00 a.m., and 250 on 05/09/19 at 11:00 a.m., and insulin had been administered per sliding scale by CMA/employee #4. A resident is considered an unstable diabetic when the hemoglobin A1c is greater than 7.0, and/or glucose levels are under 80 or more than 140 fasting, or more than 180 two hours after a meal, more than three times in a six month period. On 07/11/19 at 10:00 a.m., the employees' work schedules were reviewed with a human resource employee, who stated there was not a licensed nurse in the building on 05/01/19 through 05/10/19, for the 7:00 a.m. to 3:00 p.m. or 3:00 p.m. to 11:00 p.m. shifts (day and evening shift). On 07/16/19 at 11:30 a.m., the LPN/DON stated the CMAs who were advanced in insulin administration, administered insulin to resident #8	N1432		

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N1432	Continued From page 4 from 05/01/19 through 05/03/19 and 05/06/19 through 05/09/19, when there was not a licensed nurse in the building. She stated resident #8 was considered an unstable diabetic and the CMAs should not have administered the insulin without a licensed nurse in the building.	N1432		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure certified medication aides with advanced training in administration of insulin, respiratory medications, and glucose monitoring had their skills validated prior to performing the tasks for 5 (#2, 8, 9, 11, and #12) of 5 sampled medication employees. Additionally, the center failed to perform annual reviews for insulin administration, glucose monitoring and/or respiratory medication administration for any of the certified medication aides who had advanced training. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 07/16/19 at 11:30 a.m., licensed practical nurse/director of nursing (LPN/DON) stated the	N1442		

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N1442	Continued From page 5 skills checklist did not include the administration of insulin, respiratory treatments, or glucose monitoring. She stated she did not have documentation the skills had been validated annually or prior to the employees' performance of the tasks.	N1442		
N1484 SS=E	310:677-13-11 (b)(10)(11)(12) Facility Policies And Procedures (b) If a facility uses certified medication aides that have completed an advanced training program and demonstrated competency for care of diabetes or other specialized training modules, the facility policies and procedures shall address subsection (a) of this section and: (10) Following physician orders, including use of sliding scale orders prescribed by physicians; (11) Safety and infection control; and (12) Minimum qualifications for CMA's and facility screening of applicants, to include assurance that each certified medication aide has the physical and mental capability to safely perform duties. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure policies and procedures were in place for	N1484		

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N1484	Continued From page 6 insulin administration. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 07/09/19 at 11:06 a.m., certified medication aide (CMA)/employee #3, who had received advanced training in insulin administration, drew up insulin from a vial and then recapped the needle. She then administered the insulin to resident #10 and re-capped the needle before she disposed of it in the Sharp's container in the resident's room. CMA/employee #3 stated she knew she was not supposed to re-cap the needle. She stated she was not sure of the policy or procedure for insulin administration and re-capping needles. On 07/11/19 at 1:35 p.m., a consultant pharmacist was in the center at the time of survey, and stated lancets were single use and needles should not be re-capped. The pharmacist stated the insulin pens should be dated when they are opened because the expiration date depends on the date the insulin pen was opened. At 2:11 p.m., licensed practical nurse (LPN) #1 stated the employees should never re-cap needles. She stated it was a safety and infection control issue. LPN #1 stated she could not find their policy on insulin administration. POLICY An undated policy for infection control documented, "...The community shall ensure infection control safety practices are utilized by all staff..."	N1484		

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STATE FORM

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C 521	Continued From page 8 records. RESIDENT #8 Resident #8 moved into the center on 02/14/19 with diagnoses that included diabetes, stage 4 kidney disease, hypothyroidism, hypertension, and pain. There was no admission assessment in her records. RESIDENT #11 Resident #11 moved into the center on 03/21/19 with diagnoses that included essential hypertension and dementia. There was no admission assessment in his records. RESIDENT #14 Resident #14 moved into the center on 12/28/18 with diagnoses that included gout and hyperlipidemia. There was no admission assessment in his records. RESIDENT #15 Resident #15 moved into the center on 03/09/19 with diagnoses that included hypertension, hyperlipidemia and a history of prostate cancer. There was no admission assessment in his records.	C 521		

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C 521	Continued From page 9 On 07/16/19 at 11:45 a.m., the sampled residents' records were reviewed and there was no admission assessments available as required for the above residents. Licensed practical nurse/director of nursing (LPN/DON) stated she could not find the assessments and she did not know where the assessments were at the time of survey.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to complete the comprehensive assessments as required for 9 (#2, 4, 6, 7, 8, 10, 11, 14, and #15) of 15 sampled residents. This resulted in the potential for more than minimal harm at a pattern. Findings:	C 522		

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C 522	Continued From page 10 RESIDENT #2 Resident #2 moved into the center on 04/22/19 with diagnoses that included stroke (cerebrovascular accident), hypertension, atrial fibrillation, hyperlipidemia, dementia, and seizure precautions. There was no 14 day comprehensive assessment found in his records. On 07/15/19 at 5:55 p.m., licensed practical nurse (LPN) #1 stated no 14 day assessment had been completed for resident #2. Resident #2 moved into the center on 06/19/14 with diagnoses that included neuropathy and hypercholesterolemia. She was placed on hospice care earlier this year for failure to thrive, severe weight loss, and pain management. The most recent assessment for resident #4 was an annual, dated 09/01/18. There was no significant change assessment completed when resident #4's condition decreased in mobility/physical function and nutrition/weight loss and was placed on hospice care. On 07/16/19 at 11:43 a.m., LPN/director of nursing (DON) stated she did not know when resident #4 started to receive hospice services and did not know why a significant change assessment had not been completed for her. RESIDENT #6 Resident #6 moved into the center on 06/01/18 with diagnoses that included Parkinson's disease, coronary artery disease, depression, vitamin D deficiency, low blood pressure, benign prostatic	C 522		

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C 522	Continued From page 11 hypertrophy, gastroesophageal reflux disease, right hip and low back pain, hypothyroidism and atrial fibrillation. There was no annual comprehensive assessment found in his records. RESIDENT #7 Resident #7 moved into the center on 08/06/18 with diagnoses that included autism spectrum disorder, diabetes mellitus, speech language communication disorder, hypertension, and hypercholesterolemia. There was no 14 day comprehensive assessment found in his records. RESIDENT #8 Resident #8 moved into the center on 02/14/19 with diagnoses that included diabetes, stage 4 kidney disease, hypothyroidism, hypertension, and pain. There was no 14 day comprehensive assessment found in her records. RESIDENT #10 Resident #10 moved into the center on 03/02/17 with diagnoses that included chronic obstructive pulmonary disease, coronary artery disease, sleep apnea, diabetes, and gastroesophageal reflux disease. The most current comprehensive assessment found in her records was dated 03/16/18. RESIDENT #11	C 522		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER QUAIL RIDGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 522	Continued From page 12 Resident #11 moved into the center on 03/21/19 with diagnoses that included essential hypertension and dementia. There was no 14 day comprehensive assessment found in his records. RESIDENT #14 Resident #14 moved into the center on 12/28/18 with diagnoses that included gout and hyperlipidemia. There was no 14 day comprehensive assessment found in his records. RESIDENT #15 Resident #15 moved into the center on 03/09/19 with diagnoses that included hypertension, hyperlipidemia, and a history of prostate cancer. There was no 14 day comprehensive assessment found in his records. On 07/16/19 at 11:45 a.m., the sampled residents' records were reviewed and there was no comprehensive assessments available as required for the above residents. The LPN/DON stated she could not find the assessments and she did not know where the assessments were at the time of survey.	C 522		
C 532 SS=E	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status;	C 532		

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QUAIL RIDGE SENIOR LIVING

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C 532	Continued From page 13 (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure all required components were included in the comprehensive assessment for 6 (#1 through #5 and #7) of 8 sampled residents who had completed comprehensive assessments. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #1 Resident #1 had a documented admission date of 09/12/13. An annual assessment, dated 06/18/19, did not include mental health history or height. On 07/15/19 at 5:52 p.m., licensed practical nurse (LPN) #1 stated she probably forgot or something and that she was not sure.	C 532		

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C 532	Continued From page 14 RESIDENT #2 Resident #2 had a documented admission date of 04/22/19. A comprehensive assessment, dated 06/19/19, did not include history of infections, mental health history, or height and weight. On 07/15/19 at 6:05 p.m., LPN #1 stated she was not sure why the assessment contained blanks on the required components. RESIDENT #3 Resident #3 had a documented admission date of 04/18/17. An annual assessment, dated 07/02/19, did not include medications and dosages, nor mental health history. On 07/15/19 at 6:05 p.m., LPN #1 stated the resident's medication administration had been attached and she was not sure what to document on mental health history. RESIDENT #4 Resident #4 had a documented admission date of 06/19/14. An annual comprehensive assessment, dated 07/19/16, that did not include medications and dosages, nor history of infections or prior medical history. On 07/15/19 at 3:37 p.m., LPN/director of nursing (DON) stated she did not know who had completed the assessment or about the missing required components. Resident #5 Resident #5 had a documented admission date of	C 532			

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C 532	Continued From page 15 03/28/19. A comprehensive assessment, dated 03/28/19, did not history of infections and prior medical history. On 07/15/19 at 4:05 p.m., LPN/DON stated she did not know about the missing components on the assessment because she was not employed at the time the assessment was completed. RESIDENT #7 Resident #7 had a documented admission date of 08/06/18. A comprehensive assessment was dated 07/12/16, did not include history of infections or prior medical history, nor medications and dosages. On 07/15/19 at 4:05 p.m., LPN/DON stated she did not know why the required components were missing.	C 532		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall 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 this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had	C 543		

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C 543	Continued From page 16 been conducted between the resident or the resident's representative and the person completing the assessment form for 5 (#1 through #5) of 7 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #1 Resident #1 moved into the center on 09/12/13 with diagnoses that included dementia, hypertension, hearing loss, and cerebrovascular accident (stroke). His most current annual assessment, dated 06/08/19, did not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment. On 07/15/19 at 5:52 p.m., licensed practical nurse (LPN) stated his daughter had not been in the center since the assessment was completed. RESIDENT #2 Resident #2 moved into the center on 04/22/19 with diagnoses that included dementia, hypertension, trans-ischemia attacks, weakness, diabetes mellitus type II, hypothyroidism, hyperlipidemia, osteoporosis, coronary artery disease, and gastroesophageal reflux disease. Her most current annual assessment, dated 04/17/19, did not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment. On 07/15/19 at 6:05 p.m., LPN #1 stated she did not know why the personal interview signature	C 543		

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C 543	Continued From page 17 was missing. RESIDENT #3 Resident #3 moved into the center on 04/18/17 with diagnoses that included bipolar manic, diabetic mellitus type I, coronary artery disease, hypertension, gastroesophageal reflux disease, nicotine dependence, asthma, hyponatremia, hypolipidemia, depression, anxiety, chronic back pain, osteoarthritis, and vitamin D deficiency. Her most current annual comprehensive assessment, dated 07/02/19, did not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment. On 07/10/19 at 10:00 a.m., resident #3 was interviewed and found to be alert and oriented to person, place, and situation. On 07/15/19 at 6:05 p.m., LPN #1 stated she had not gotten back to get the resident's signature. RESIDENT #4 Resident #4 moved into the center on 06/19/14 with diagnoses that included neuropathy and hypercholesterolemia. Her most current annual comprehensive assessment, dated 09/01/18, did not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment. On 07/16/19 at 11:43 a.m., LPN/director of nursing (DON) stated she did not know why a personal interview had not been conducted.	C 543		

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C 543	Continued From page 18 RESIDENT #5 Resident #5 moved into the center on 03/28/19 with diagnoses that included atrial fibrillation, diastolic heart failure, dementia, benign prostatic hypertrophy, and osteoarthritis. His most current comprehensive assessment, dated 03/28/19, did not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment. On 07/16/19 at 11:46 a.m., LPN/DON stated she did not know why a personal interview had not been conducted.	C 543		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure registered nurse supervision for the storage of insulin, administration of insulin, and glucose monitoring. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings:	C 911		

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C 911	Continued From page 19 An Oklahoma State Department of Health incident report, dated 02/21/19, documented certified medication aide (CMA)/employee #4 administered resident #8 the wrong dose of her fast-acting insulin. The CMA administered 25 units of Humalog insulin when the resident's blood sugar was eighty-five. (Humalog starts to work in 15 minutes after injection, peaks in one hour, and keeps working for 2 to 4 hours.) The resident's usual dose of Humalog was from 4 to 12 units if the resident's blood sugar was 176 or greater per the sliding scale. A treatment administration record for resident #8, dated 05/2019, did not document the resident's blood sugar readings or amount of insulin administered 5 times. Glucose monitoring logs documented resident #8 was administered the wrong dose of insulin per her sliding scale on 06/10/19 and 07/05/19 by CMA/employee #4. On 07/09/19 at 11:06 a.m., CMA/employee #4, who had received advanced training in insulin administration, re-capped a needle on an insulin syringe after drawing up the insulin and after administering insulin to resident #10. CMA/employee #4 stated she knew she was not supposed to re-cap the needle. On 07/11/19 at 11:20 a.m., licensed practical nurse (LPN) #3 obtained resident #8's glucose reading via sticking the resident's fingertip with a lancet device (device with a needle used to prick the finger to obtain a small blood sample.) LPN #3 did not place a new lancet in the device prior to sticking the resident's finger, and did not remove the lancet after he stuck the resident's	C 911		

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C 911	Continued From page 20 finger. He placed the lancet device in a container and put it away. LPN #3 placed a needle on an insulin pen, stuck it into resident #8, and then realized he had not dialed the dose of insulin to be administered. The LPN removed the pen, re-capped the needle with the inner cap, and removed the needle and re-stuck the resident with a new needle and re-capped the needle with the inner cap after he administered the insulin. LPN #3 removed the needles from the insulin pen, placed them in a basket, and disposed of them in the clinic area. Resident #8 had a Sharp's container (used to discard needles and lancets for safety) in her room. At 11:35 a.m., LPN #3 re-capped the needle on an insulin syringe after drawing up the insulin and after administering the insulin to resident #18. LPN #3 did not use a new lancet prior to checking the residents blood sugar and did not remove the lancet after he checked the resident's blood sugar. LPN #3 placed the lancet device with the used needle on it in a pouch and put it in the treatment cart. LPN #3 did not clean the glucose meter or lancet device. At 11:52 a.m., LPN #3 stated he did not change out the lancets on the lancet devices. He stated he re-capped the needles so the needle wouldn't become contaminated prior to administering the insulin, and re-capped it after administering the insulin so he would not get stuck. He stated he did not see the Sharp's container in the residents' rooms. At 1:35 p.m., a consultant pharmacist was in the center at the time of survey, and stated lancets were single use and needles should not be	C 911		

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C 911	Continued From page 21 re-capped. The pharmacist stated the insulin pens should be dated when they are opened because the expiration date depends on the date the insulin pen was opened. At 2:11 p.m., LPN/director of nursing (DON) stated the employees should not re-cap needles and should not re-use the lancets. She stated she had not informed the registered nurse (RN) of the employees re-capping the needles. At 2:49 p.m., the LPN/DON observed the treatment cart that contained six opened insulin pens without open dates documented on the insulin. (Insulin expires between 28-42 days after it is opened depending on the type of insulin.) She stated maybe the employees were not aware they needed to date the insulin pens. On 07/15/19 at 5:36 p.m., LPN #2 stated she had not received training from the registered nurse or the licensed practical nurse on insulin administration upon hire in the center. On 07/16/19 at 11:30 a.m., the LPN/DON stated the CMAs who were advanced in insulin administration, administered insulin to resident #8 from 05/01/19 through 05/03/19 and 05/06/19 through 05/09/19, when there was not a licensed nurse in the building. She stated resident #8 was considered an unstable diabetic and the CMA should not have administered the insulin without a licensed nurse in the building. There was no skills validation for administering insulin and checking glucose levels available for CMA/employee #4, nor was the center able to provide policies or procedures for administering insulin and checking glucose levels.	C 911		

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C 911	Continued From page 22 A standard instructions for insulin pens documented to remove the outer needle cover (larger needle cover over the inner needle cover) and save for safe removal of the needle after administration of the insulin. A leaflet for the lancets documented, "...For a virtually pain-free test and to avoid infection, use a new lancet each time you perform a fingertip test..."	C 911		
C 954 SS=F	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure: a) 8 (licensed practical nurse (LPN) #2, LPN #3, #4, 12, 28, 34, 41, and #47) of 42 recently hired direct care employees were trained in first aid; b) 1 (#22) of 42 recently hired direct care employees was trained in cardiopulmonary resuscitation (CPR); and c) 32 (LPN/director of nursing (DON), #5, #8 through #10, #15 through #21, #23 through #27, #29 through #33, #36 through #40, and #42 through #46) of 42 recently hired direct care employees were trained in both CPR and first aid.	C 954		

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C 954	Continued From page 23 These failed practices resulted in the widespread potential for more than minimal harm. Findings: FIRST AID On 07/10/19 at 4:06 p.m., a review of recently hired direct care employee files was conducted and contained no documentation to verify the following direct care employees, long term care aide (LTCA) or certified medication aide (CMA), and LPNs had been trained in first aid: LPN #2 - hired 05/22/19; LPN #3 - hired 05/22/19; LTCA/CMA/employee #4 - hired 07/02/18; LTCA/CMA/employee #12 - hired 08/20/18; LTCA/employee #28 - hired 04/25/19; LTCA/employee #34 - hired 01/28/19; LTCA/employee #41 - hired 03/14/19; and LTCA/CMA/employee #47 - hired 02/26/19. The review of recently hired direct care employee files revealed only one direct care employee, LTCA/employee #22's file contained no documentation to verify she had been trained in CPR. CPR AND FIRST AID The review of recently hired direct care employee files revealed no documentation was provided to verify the following direct care LPN/DON, LTCA, CMA, transporter, and dietary servers had been trained in CPR and first aid: LPN/don - hired 05/14/19; LTCA/CMA/employee #5 - hired 05/16/19; LTCA/CMA/employee #8 - hired 03/21/19; LTCA/CMA/employee #9 - hired 04/08/19;	C 954		

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C 954	Continued From page 24 LTCA/CMA/employee #10 - hired 06/11/19; LTCA/employee #15 - hired 01/28/19; LTCA/employee #16 - hired 11/24/18; Dietary server/employee #17 - hired 08/27/18; LTCA/employee #18 - hired 01/26/19; LTCA/employee #19 - hired 03/26/19; Dietary server/employee #20 - hired 05/01/19; Dietary server/employee #21 - hired 02/13/19; LTCA/CMA/employee #23 - hired 08/27/18; LTCA/employee #24 - hired 05/10/19; LTCA/CMA/employee #25 - hired 06/22/19; LTCA/employee #26 - hired 06/26/19; LTCA/employee #27 - hired 05/16/19; Transporter/employee #29 - hired 12/20/18; LTCA/employee #30 - hired 06/26/19; LTCA/employee #31 - hired 07/05/19; Dietary server/employee #32 - hired 05/21/19; LTCA/employee #33 - hired 02/25/19; LTCA/employee #36 - hired 01/28/19; LTCA/employee #37 - hired 04/25/19; LTCA/employee #38 - hired 05/03/19; LTCA/employee #39 - hired 04/22/19; LTCA/employee #40 - hired 03/21/19; LTCA/employee #42 - hired 06/25/19; Dietary server/employee #43 - hired 04/11/19; Activity/LTCA/employee #44 - hired 02/25/19; LTCA/employee #45 - hired 05/22/19; and Dietary server/employee #46 - hired 05/01/19. At 5:02 p.m., the human resource employee was asked for any documentation related to direct care employees that had received training in first aide and CPR. She stated there was going to be 'big gapping holes' on that. She further stated there were no certified direct care employees in the dining room during mealtimes, and only the servers were in there with the residents.	C 954		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5523	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2019
NAME OF PROVIDER OR SUPPLIER QUAIL RIDGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 25	C1505		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

QUAIL RIDGE SENIOR LIVING

12401 TRAIL OAKS DRIVE
OKLAHOMA CITY, OK 73120

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/16/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

QUAIL RIDGE SENIOR LIVING

**12401 TRAIL OAKS DRIVE
OKLAHOMA CITY, OK 73120**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 27 finger. He placed the lancet device in a container and put it away. At 11:35 a.m., LPN #3 obtained resident #18's glucose reading via a lancet device. He did not place a new lancet on the device prior to sticking the residents finger, and did not remove the used lancet after he stuck the resident's finger. LPN #3 placed the lancet device with the used needle on it in a pouch and put it in the treatment cart. LPN #3 did not clean the glucose meter or lancet device. At 11:52 a.m., LPN #3 stated he did not change out the lancets on the lancet devices at anytime during the procedures. At 1:35 p.m., a consultant pharmacist was in the center at the time of survey and stated lancets were single use. At 2:11 p.m., LPN/director of nursing (DON) stated the employees should not re-use the lancets. No policies and procedures on glucose monitoring was available or provided. A leaflet for the lancets documented, "...For a virtually pain-free test and to avoid infection, use a new lancet each time you perform a fingertip test..."	C1505		

STATE WORKLOAD REPORT

Provider/Supplier Number AL5523	Provider/Supplier Name QUAIL RIDGE SENIOR LIVING
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Type of Survey (select all that apply)

2	3			
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. <i>ml</i> 25837	07/08/2019	07/16/2019	0.50	0.00	35.75	1.50	10.00	10.50
2. <i>ml</i> 35195	07/08/2019	07/16/2019	1.00	0.00	4.75	0.00	2.75	0.50
3. <i>ml</i> 36191	07/08/2019	07/16/2019	0.50	0.00	33.25	1.50	11.25	12.75
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours..... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours.... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

AUG 16 2019

fm



Oklahoma State Department of Health
Creating a State of Health

September 3, 2019

License Number: AL5523

Ms. Cheryl Seabaugh, Administrator
Quail Ridge Assisted Living Center
12401 Trail Oaks Drive
Oklahoma City, OK 73120

RE: Survey Event BKIM11

Dear Ms. Seabaugh:

On July 16, 2019, a Licensure inspection 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 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 **September 28, 2019**.

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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/KS

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Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 8/28/2013

Facility Name: Quail Ridge Senior Living

License Number: AL5523

Survey Event ID: BKIM11

Date Survey Completed: 7/16/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1105

Based on: interview and record review, it was determined the center failed to ensure two hours of in-service training specific to their job duties were provided monthly for all long term care aides (LTCA) who provided direct resident care. This failed practice had the widespread potential for more than minimal harm for all 147 residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The new Director of Nursing will conduct all required monthly in-service trainings for nursing staff and LTCA's. A registered nurse will supervise required monthly in-service trainings. The Human Resources department will ensure that LTCA's receive an annual performance review. The Human Resources department and the new Director of Nursing will ensure that the LTCA's certifications are current (not expired).

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 have the potential to be affected by the current 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?

a) The new Director of Nursing will conduct the monthly required in-service training.
b) A registered nurse will supervise the monthly required in-service training.
c) The Human Resources department will provide the new Director of Nursing with the status of LTCA's certifications monthly for review and updating measures.
c) The new Director of Nursing will ensure that the in-service documentation of the in-service topic, dated with start and stop times is placed in the In-Service Trainings Binder.

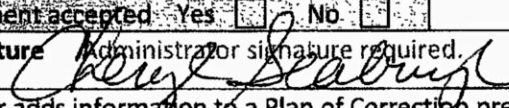
OSDH Response: Element accepted Yes ☐ No ☐

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.

Random audit will be done monthly by the Admin Director to ensure compliance.

The new Director of Nursing will notify Admin Director of completion of monthly in-service training. The Human Resource department will notify the Admin Director of communication sent to the new Director of Nursing about the LTCA's certification status.

		The new Director of Nursing will bring documentation of the monthly in-service training to the monthly QA meeting for review. Monthly QA meeting documentation will be maintained in the QA Meeting Binder.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		9/28/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date 8/28/2019	
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.			



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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 8/28/2013

Facility Name: Quail Ridge Senior Living

License Number: AL5523

Survey Event ID: BKIM11

Date Survey Completed: 7/16/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1432

Based on: interview and record review, it was determined the center failed to ensure a physician or licensed nurse was on site when insulin was administered by certified medication aides with advanced training (CMA) to 1(#8) of 1 sampled resident who required insulin administration for unstable diabetes. This failed practice had the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

- 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.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator's signature required.

Date 8/28/2019

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A licensed practical nurse (LPN) will conduct all blood sugar monitoring and insulin injections for all residents who have unstable diabetes.

All residents who have unstable diabetes have the potential to be affected by the current practice.

a) A licensed practical nurse (LPN) will conduct all blood sugar monitoring and insulin injections for all residents who have unstable diabetes.
b) Certified med aides (CMA) or CMA's with advanced training will not be allowed to conduct blood sugar monitoring and insulin injections for any resident with unstable diabetes.

The new Director of Nursing and a registered nurse (RN) will audit the treatment records (TAR) monthly for compliance.

The new Director of Nursing and a registered nurse (RN) will audit the treatment records (TAR) monthly for compliance.

The new Director of Nursing will provide TAR audit review for monthly QA meeting.

Treatment records (TAR) documentation will be maintained with TAR records.

9/28/2019

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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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.



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 8/28/2013

Facility Name: Quail Ridge Senior Living

License Number: AL5523

Survey Event ID: BKIM11

Date Survey Completed: 7/16/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1442

Based on: interview and record review, it was determined the center failed to ensure certified medication aides with advanced training in administration of insulin, respiratory medications, and glucose monitoring had their skills validated prior to performing the tasks for 5 (#2, 8, 9, 11, and #12) of 5 sampled medication employees, additionally, the center failed to perform annual reviews for insulin administration, glucose monitoring and/or respiratory medication administration for any of the certified medication aides who had advanced training. This failed practice had the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The new Director of Nursing will update the current Competency Skills Checklist Sheet to include injections, respiratory and glucose monitoring.

All residents have the potential to be affected by the current practice.

- The new Director of Nursing will update the current Competency Skills Checklist Sheet to include injections, respiratory and glucose monitoring.
- This updated document will be completed for each certified medication aide staff prior to medication administration and on an annual basis by a licensed practical nurse (LPN), or the new Director of Nursing.

The new Director of Nursing will ensure the completed, updated Competency Skills Checklist Sheets will be maintained in a Competency Skills Checklist binder.

The Human Resources department will conduct a random audit of the binder monthly.

The new Director of Nursing will provide a review of the Competency Skills Checklist Sheets for the monthly QA meeting.

Documentation of the Competency Skills Checklist will be maintained in a Competency Skills Checklist binder.

9/28/2019