Oklahoma State Department of Health
Creating a State of Health

December 12, 2019

License Number: AL5523

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

Survey Event ID: 16OR11

Dear Ms. Seabaugh:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **October 9, 2019**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **Oklahoma City, OK, 73120**
Provider #: **Al 5523**
Complaint #: **OK00054091**
Investigation Date(s): **10/08/19 and 10/09/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care and services according to contract.	US

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

An unannounced on-site investigation was initiated on 10/08/2019 at 1:50 p.m.

A sample of three 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 provision of personal care to include incontinent care, medication administration, and pests was conducted.

Observations were made in the memory care unit throughout both days of the survey, to include residents' grooming, odors, flies, cleanliness of the common areas, residents' rooms and bathrooms, and care provided to residents dependent for incontinent care. Only one fly was seen on a wall between the medication room and dining room. No offensive odors or feces were observed on any resident or in any part of the unit. Employees were observed as they attended their duties of medication administration and provision of care to residents.

Interviews with three family members and five employees revealed care had been provided to residents as needed and no concerns were identified. All of the family members and employees stated the usual response to call bells was from five to 20 minutes on average. One employee stated she monitored the call bell response times, reported to the administrator if the response time was over 30 minutes, which was uncommon; and usually it was a glitch in being able to reset the call bell.

Reviews of employee work schedules, to include the July 2019 schedule, revealed there was always a trained employee on duty and available to administer medication, and a licensed practical nurse was on duty in the center 24 hours a day. 'Town Hall Meeting' minutes for the month of July 2019 were reviewed and there were no concerns voiced from residents regarding care and services, flies, or medication administration.

At the time of the investigation, there was no deficient practice related to incontinent care, medication administration, or flies in the center.

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.

Marie Remer, RN, CHFS IV

Date report completed: 10/10/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5523	A. BUILDING: _____ B. WING _____	10/09/2019

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
C 000	INITIAL COMMENTS An abbreviated survey was conducted on 10/08/19 and 10/09/19 to investigate complaint OK00054091. Current census was 149. No deficient practice was cited.	C 000		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5523	QUAIL RIDGE SENIOR LIVING

Type of Survey (select all that apply)

[3][ ][ ][ ][ ]

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

Extent of Survey (select all that apply)

[ ][ ][ ][ ][ ]

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. MT 25837	10/08/2019	10/09/2019	0.50	0.00	4.00	1.25	2.00	1.50
2.								
3.								
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**

DEC 13 2019 jm