OKLAHOMA
State Department
of Health

Delivery via email to: rmarchbanks@quailridgeassistedliving.com

August 17, 2021

License Number: AL5523

Mr. Robert Marchbanks, Administrator
Quail Ridge Senior Living
12401 Trail Oaks Drive
Oklahoma City, OK 73120

Survey Event ID: 4QER11

Dear Mr. Marchbanks:

On **August 5, 2021,** 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.

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

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

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

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(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 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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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.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.08.17 11:32:50 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **Oklahoma City, OK, 73120**
Provider #: **AL5523**
Complaint #: **OK00056105**
Investigation Date(s): **08/04/21 and 08/05/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure the legal representative was contacted with a change in condition/and ensure medications were administered as ordered/care was provided according to the resident's contract.	S

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

An unannounced on-site investigation was initiated 08/04/2021 at 9:00 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C5010 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation number one. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Bobbi Bridges

Bobbi Bridges, RN, CHFS

Date report completed: 08/10/2021

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 #: **AL5523**
Complaint #: **#OK00057485**
Investigation Date(s): **08/04/21-08/05/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care according to the resident contract.	**S**
2. The center failed to ensure proper medication administration.	**S**

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

An unannounced on-site investigation was initiated on 08/04/2021 at 09:30 a.m.

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

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-1512 for details.

An investigation specific to medication administration and storage, contracted services, and personal care services was investigated.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-1512 for details.

An investigation specific to proper medication administration was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Julie Edmiaston Digitally signed by Julie Edmiaston
Date: 2021.08.16 17:14:51 -05'00'

Julie Edmiaston RN, BSN

Bobbi Bridges RN

Date report completed: 08/09/2021

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 _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL RIDGE SENIOR LIVING	12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120

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C 000	INITIAL COMMENTS On 08/04/21 through 08/05/21 an abbreviated survey was conducted to investigate complaint #OK00057485 and #OK00056105. Resident Census 173.	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to perform a significant change assessment for one (#3) of six sampled residents who reside at the center. This deficient practice had the isolated potential for more than minimal harm. Findings: The center's comprehensive assessment for resident #3, dated 02/17/21, documented the number of persons required to assist the resident with activities of daily living (ADL's). Bathing (1), Eating (0), Dressing (0), Transferring (0), Toileting (0), and Ambulation (0). On 08/04/21 at 11:55 a.m., certified nurse aide (CNA) #4 was asked about the resident's care. She stated he showered on Tuesdays,	C 522		

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C 522	Continued From page 1 Thursdays, and Saturdays. She stated the director of nurses (DON) reported to her the previous week the resident needed more care. She stated she used to provide care by herself and now he required two-person assist. At 12:43 p.m., the assisted director of nurses (ADON)/licensed practical nurse (LPN) was asked if the comprehensive assessment currently reflected the resident's condition. She stated he had declined since February 2021. She stated the resident was not independent with transferring, toileting and ambulation, and the comprehensive assessment needed to be updated. The shower log for the resident, dated 07/29/21, documented he refused his shower and the schedule was changed from a one-person assist to a two-person assist.	C 522		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to individualize the plan of care for one (#3) of six sampled resident care plans. This deficient	C 552		

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C 552	Continued From page 2 practice had the isolated potential for more than minimal harm. Findings: The center's resident service/care plan for resident #3, dated 09/23/19 through 09/23/20, documented the resident was independent with ambulation, transfers, dressing, grooming, incontinent care, dining, required no staff modifications at meal times, and required assistance with bathing (15-30) minutes. At 2:30 p.m., resident #3 was asked if the staff assisted him with dressing in the morning. He stated, "yes." The dry erase board in his room documented to take the resident to the dining room for all meals. The center's contract for the resident, dated 06/12/17, documented the monthly fee included individualized care plans.	C 552		
C 911 SS=F	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;	C 911		

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C 911	Continued From page 3	C 911		

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 (RN) supervision for medication administration, for proper storage of medications, and supervision of ADL's (activities of daily living) as described in the center's contract to:

~ provide supervision of shower assistance as outlined in the center's contract for one (#3) of one sampled resident identified.

~ supervise and provide assistance with medication administration and storage of medications for one (#3) of four sampled residents with medication assistance.

These failed practices had the widespread potential for more than minimal harm for 173 residents who reside at the center with an identified need for medication assistance and/or assistance with ADL's. Findings:

Documentation for shower assistance provided to resident #3 for the month of July 2021 was reviewed. The shower logs labeled Quail Ridge Bath Schedule listed the resident's name on 07/29/21 as a refusal for a shower and the schedule was changed from a one-person assist to a two-person assist. The logs documented the resident received a shower on 07/27/21. The remaining logs for the month of July did not include the resident's name to receive shower assistance.

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C 911	Continued From page 4 The center's contract for the resident, dated 06/12/17, documented, "...provide nursing supervision: The prospective resident may require nursing supervision including supervision of medication administration, supervision of ADL (activities of daily living)..." On 08/04/21 at 11:55 a.m., the certified nurse aide (CNA) #4 was asked if she knew about medications being left at the resident's bedside. She reported not recently. The CNA reported she would occasionally find his night time medications at his bedside. She was asked what she did when she found the medications at his bedside. She reported she would inform the medication aide so she could document. At 2:30 p.m., the resident was asked about the staff assistance for his showers. He reported the staff used to assist, but did not anymore. The resident was observed sitting in a chair in his room and was unshaven. The dry erase board in the resident's room documented, "do not leave pills at the bedside." The resident reported staff had occasionally left medications in his room but not recently.	C 911		
C1505 SS=F	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	C1505		

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C1505	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to secure medications and ensure the medication rooms were locked when left unattended. Medications were reported to be left at the bedside for one (#3) of four sampled residents with medication assistance. These deficient practices had the widespread potential for more than minimal harm for all 173 residents who resided at the center. Findings:	C1505		

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C1505	Continued From page 6 On 08/04/21 at 10:15 a.m., the medication door was observed to be open. The surveyor entered the North hall medication room with certified nurse aide (CNA) #1 and opened the door to the medication cabinet and the refrigerator where medications were stored. The CNA was asked if the door to the medication room was left opened. She stated, "Yes, I guess so." She was asked if the cabinet in the medication room was locked. She stated, "I assume not." She was asked if the medication refrigerator was locked. She stated, "No, I assume not either." She was asked if she knew why the medication room was not locked and secure. She reported when the advanced certified medication aide (ACMA) #2 left the medication room, she did not make sure the door was locked. At 10:45 a.m., ACMA #2 was interviewed on the 100 hall and asked about the medication room being unlocked on the North hall. The medication room door was observed to be cracked open on the first 100 hall and she was walking away from medication room. She was asked why the medication door was left open. She stated she had never locked it, but could check to see if the key was on her key ring. At 11:55 a.m., staff assisted resident #3 to a chair in the common area next to the Bistro. CNA #4 was asked if she found medications at the resident's bedside. She stated, "not lately." She stated she would occasionally find his night time medications at the bedside. She was asked what she did when she found the medications at his bedside. She reported she would inform the medication aide so she could document. At 2:30 p.m., the dry erase board in resident #3's room documented, "do not leave pills at the	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 7 bedside." The resident was asked if the staff left medications at his bedside. He stated, "not lately." He was asked what he meant by not lately. He reported staff would leave medications every now and then but not recently. On 08/05/21 at 08:53 a.m., ACMA #2 reported she had a key to the North hall medication room. She reported she also had the key to the medication room on the first 100 hall, but the door was too hard to open and close. She stated she had to "jiggle and wiggle" the key around to get it to work. She was asked about training and if someone observed her pass medications. She stated, "yes." She reported she was used to working in facilities where the doors locked automatically. She was asked if she was trained to keep the medications locked up. She stated she did not know if the key to the first 100 hall was on her key ring, because the girl who trained her did not know about it either. The center's contract for the resident, dated 06/12/17, documented, "...provide nursing supervision: The prospective resident may require nursing supervision including supervision of medication administration, supervision of ADL (activities of daily living)..."	C1505		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice.	C1951		

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C1951	Continued From page 8 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to: ~provide an accurate clinical record for a resident with an emergency transfer from the center to a nearby hospital for one (#1) of one closed record reviewed. ~ provide an accurate clinical record of known occurrences related to medication administration for one (#3) of one sampled resident with medications left at the bedside. These deficient practices had the potential for more than minimal harm at a pattern. Findings: 1. Resident #1 was admitted on 06/01/20, with diagnoses which included diabetes mellitus, heart disease, and dementia. An assessment, dated 06/01/20, documented the resident was alert, ambulatory, able to feed self, no chewing or swallowing problems and skin was intact. The clinical record was reviewed and contained no documentation of a change in status requiring an emergency transfer to the hospital. The record did not contain notification from the center to the resident's representative. The hospital records, dated 08/29/20, documented the resident was admitted for IV therapy for diagnosis of facial cellulite. On 08/05/21 at 12:15 p.m., the administrator was interviewed and agreed the records should be included in the clinical record. She placed a call to the home health agency requesting all records.	C1951		

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QUAIL RIDGE SENIOR LIVING	12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120

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C1951	Continued From page 9 2. Resident #3. On 08/04/21 at 11:55 a.m., the certified nurse aide (CNA) #4 was asked if she knew about medications being left at the resident's bedside. She reported not recently. The CNA reported she would occasionally find his night time medications at his bedside. She was asked what she did when she found the medications at his bedside. She reported she would inform the medication aide so she could document. At 2:30 p.m., the dry erase board in the resident's room documented, "do not leave pills at the bedside." The resident reported staff had occasionally left medications in his room but not recently. On 08/05/21 at 11:30 a.m., the assistant director of nurses (ADON)/licensed practical nurse (LPN) reported an incident when a family/responsible party of resident #3 reported medications were found at his bedside. She was asked for an incident report. She reported she did not document the incident but reported to the DON, who no longer was employed by the center. She reported she did not chart in the progress notes or on a grievance form, and did not document notification to the RN. The center's policy and procedures were reviewed and documented, ...notification to ...legal authority of change of resident status...all information regarding resident change of status is to be documented in the resident's chart. The center's policy titled, "Grievance Procedure-Resident" not dated, documented any complaints from resident/family/responsible party/legal authority will be documented on the	C1951		

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 _____	08/05/2021

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
C1951	Continued From page 10 appropriate form. The staff member taking the complaint will complete the form if immediate resolution is possible, with approval of the staff member's direct supervisor...".	C1951		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

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 _____	08/05/2021

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
C5010	Continued From page 11 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to monitor the delivery of home health services. The center failed to document and notify the resident's representative for a change in condition for one (#1) of two residents with home health services. This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #1 was admitted, 06/01/20, with diagnoses which included diabetes mellitus, heart disease, and dementia. An assessment, dated 06/01/20, documented the resident was alert, ambulatory, able to feed self, no chewing or swallowing problems and skin was intact. Hospital records, dated 08/29/20, documented the resident was admitted for IV therapy for diagnosis of facial cellulite. A physician order, dated 08/27/21, documented an oral antibiotic to be given three times a day for an infection on the chin. The clinical record was reviewed and contained no documentation of the home health visits/progress notes or a change in status requiring an emergency transfer to the hospital. The record did not contain notification from the facility to the resident's representative. The facility policy and procedures were reviewed and documented, ...notification to ...legal authority of change of resident status...all information	C5010		

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 _____	08/05/2021

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
C5010	Continued From page 12 regarding resident change of status is to be documented in the resident's chart. On 08/05/21 at 11:55 a.m., assistant director of nurses (ADON)/licensed practical nurse (LPN) reported no home health records could be found in the resident's clinical record. At 12:15 p.m., the administrator was interviewed and agreed the records should be included in the clinical record. She placed a call to the home health agency requesting all records.	C5010		

OKLAHOMA
State Department
of Health

Delivery via email to: Paula.brooks@quailridgeassistedliving.com

September 21, 2021

License Number: AL5523

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

Survey Event ID: 4QER11

Dear Ms. Brooks-:

On **August 5, 2021,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **October 29, 2021**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Sincerely,

Tempal Killman Digitally signed by Tempal Killman
Date: 2021.09.21 10:11:23 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/15/2021** **Facility Name:** QUAIL RIDGE SENIOR LIVING **License Number:** AL5523 **Survey Event ID:** 4QER11 **Date Survey Completed: 8/5/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: Based on observation, interview, and record review it was determined the center failed to perform a significant change assessment for one (#3) of six sampled residents who reside at the center.

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 Quail Ridge Senior Living as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Identified resident #3 no longer resides in the facility.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Comprehensive assessments are required for all residents, therefore, all residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Nursing staff will be in-serviced on comprehensive assessments, including significant change assessment requirements, and assessment timeframes. An audit will be conducted of the residents assessments to ensure significant change assessments have been completed as required. An assessment binder with current assessment dates and due dates will be implemented to ensure assessments are completed in a timely manner.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	. Audits will by conducted by the administrator/designee to ensure significant change assessments are completed as required. Audits will be conducted weekly x1 month then monthly x2 months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/29/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Paula Brooks	**Date 9/16/2021**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/16/2021** **Facility Name:** QUAIL RIDGE SENIOR LIVING **License Number:** AL5523 **Survey Event ID:** 4QER11 **Date Survey Completed: 8/5/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C911	Based on: Based on observation, interview, and record review it was determined the center failed to ensure RN supervision for medication administration, proper storage of medications, and supervision of ADL's as described in the center's contract to: provide supervision of shower assistance as outlined in the center's contract for one (#3) of one sampled resident identified; and supervise and provide assistance with medication administration and storage of medications for one (#3) of four sampled residents with medication assistance.

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 Quail Ridge Senior Living as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	
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 who receive bathing assistance and/or medication assistance 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?	Nursing staff will be in-serviced on providing and documenting ADL assistance as scheduled; and all licensed nurses and medication aides will be in-serviced on the administration, including the P-I-G method, and storage of medications. An audit of the residents will be conducted to identify all resident requiring bathing assistance. The bath schedule will be updated and bath sheets will be implemented as documentation of all showers provided.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	. Audits will by conducted by the administrator/designee to ensure baths are completed as required and no medications are left at the bedside. Audits will be conducted weekly x1 month then monthly x2 months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction.

OSDH Response: Element accepted Yes No			
5. On what date will corrective action be completed?		10/29/2021	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Paula Brooks			**Date 9/16/2021**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/16/2021** **Facility Name:** QUAIL RIDGE SENIOR LIVING **License Number:** AL5523 **Survey Event ID:** 4QER11 **Date Survey Completed: 8/5/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on observation, interview, and record review it was determined the center failed to secure medications and ensure the medication rooms were locked when left unattended. Medications were reported to be left at the bedside for one (#3) of four sampled residents with medication assistance.

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 Quail Ridge Senior Living as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	
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 who receive medication assistance have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All licensed nurses and medication aides will be in-serviced on the administration, including the P-I-G method, and storage of medications, including the medication rooms to be locked when left unattended.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	. Audits will by conducted by the administrator/designee to ensure medications are not left at the bedside and medication rooms are locked when unattended. Audits will be conducted weekly x1 month then monthly x2 months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/29/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	**Date 9/16/2021**

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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Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor			
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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/16/2021** **Facility Name:** QUAIL RIDGE SENIOR LIVING **License Number:** AL5523 **Survey Event ID:** 4QER11 **Date Survey Completed: 8/5/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C5010	Based on: Based on observation, interview, and record review it was determined the center failed to monitor the delivery of home health services. The center failed to document and notify the resident's representative of a change in condition for one (#1) of two residents with home health services.

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 Quail Ridge Senior Living as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Identified resident #1 no longer resides in the facility.
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 who receive home health services 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?	A coordination form will be implemented for home health agencies to complete with each visit. The forms will be reviewed daily by the nurse to ensure changes are documented and resident representatives are notified as required. Staff and home health agencies will be educated on the coordination of care form to be completed by home health with every visit.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	. Audits will by conducted by the administrator/designee to ensure coordination forms are completed, changes are documented and resident representatives are notified as required. Audits will be conducted weekly x1 month then monthly x2 months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/29/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Paula Brooks OAC 310:663-25-4(F)			**Date 9/16/2021**
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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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/16/2021** **Facility Name:** QUAIL RIDGE SENIOR LIVING **License Number:** AL5523 **Survey Event ID:** 4QER11 **Date Survey Completed: 8/5/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1951	Based on: Based on interview, and record review it was determined the center failed to provide an accurate clinical record for a resident with an emergency transfer from the center to a nearby hospital for one (#1) of one closed record reviewed; and provide an accurate clinical record of known occurrences related to medication administration for one (#3) of one sampled resident with medications left at the bedside.

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 Quail Ridge Senior Living as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Identified residents #1 and #3 no longer reside in the facility.
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 are to have an accurate clinical record, therefore, all residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Licensed nursing staff will be in-serviced on accurate documentation, related to hospital transfers and medication incidents. A binder, for nurse management to review, will be implemented for documentation of resident changes and resident incidents.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	. Audits will by conducted by the administrator/designee to ensure resident changes and resident incidents are documented. Audits will be conducted weekly x1 month then monthly x2 months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/29/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Paula Brooks	**Date 9/16/2021**

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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OKLAHOMA
State Department
of Health

Delivery via email to: Paula.brooks@quailridgeassistedliving.com

November 19, 2021

License Number: AL5523

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

Survey Event ID: 4QER12

Dear Ms. Seabaugh:

On **November 16, 2021,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **August 5, 2021,** have now been corrected effective **October 29, 2021.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 426-8200.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.11.19 08:17:35 -06'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

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 _____	R 11/16/2021

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 A revisit was conducted from 11/15/21 to 11/16/21. All deficiencies from the 08/05/21 survey were cleared.	{C 000}		

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