OKLAHOMA
State Department
of Health

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

December 22, 2021

License Number: AL5523

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

RE: Survey Event ID: MLOE11

Dear Ms. Brooks:

On **December 7, 2021**, agents from our office concluded a State Licensure survey with complaint investigations 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 December 7, 2021.

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;

(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) 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

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,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

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 #: **OK00055204**
Investigation Date(s): **November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to provide adequate and appropriate medical care.	S

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

An unannounced on-site investigation was initiated on 11/16/2021 at 10:30 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 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 C1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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 By Mary Cooper

Julie Edmiaston RN, BSN

Mary Cooper RN

Date report completed: 12/02/2021

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 #: OK00055842
Investigation Dates: November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide a sanitary environment.	US

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

An unannounced on-site investigation was initiated on 11/16/2021 at 10:30 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 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 pest control, dogs barking, and cleanliness of the environment.

A tour of the center was conducted upon arrival and throughout the survey. Resident dogs and cats were observed at the center. No fleas were observed in resident rooms with pets. There was no excessive dog barking heard during the tour. No odors were detected with animals or outside in the hallways of residents with animals.

The identified resident with the dog no longer resided at the center. Residents interviewed on the hall included the named complainant who denied any issues with dogs barking at this time.
Current pest control records were maintained at 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.

Julie Edmiaston by Pam Arden

Julie Edmiaston RN, BSN

Mary Cooper RN

Date report completed: 12/02/2021

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 #: **#OK00055861**
Investigation Date(s): **November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have adequate staff to ensure care was received as ordered by the physician.	**S**
2. The center failed to have an effective pest control program.	**US**

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

An unannounced on-site investigation was initiated on 11/16/2021 at 10:30 a.m.

A sample of twelve 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 C1505 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to pest control and environment was conducted.

A tour of the facility was conducted upon entrance to the center and throughout the survey process. There were no bed bugs observed throughout the survey and no other bugs identified during the survey.

Residents were interviewed and no complaints of bugs were identified.

Past control records dated July, August, and September 2020 were reviewed. The center maintained current pest control records.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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.

Deficient practice was unsubstantiated for allegation #2. 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.

Julie Edmiaston By Mary Cooper

Julie Edmiaston RN, BSN

Mary Cooper RN

Date report completed: 12/02/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **Oklahoma City, Okla. 73120**
Provider #: **AL5523**
Complaint #: **OK00055886**
Investigation Date(s):November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered and prescribed in a safe manner	S
2. The center failed to provide adequate care and services.	S

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

An unannounced on-site investigation was initiated on 12/16/2021 at 10:30 a.m.

A sample of 12 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 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, Tags C0921, C0922 and C1505 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0552 for details.

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.

Mary Cooper By Penn Cabin

Mary Cooper RN

Date report completed: 12/03/2021

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 #: **#OK00055906**
Investigation Date(s): **November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure qualified staff administered medications, and that medications were prepared in a safe manner.	S

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

An unannounced on-site investigation was initiated on 11/16/2021 at 10:30 a.m.

A sample of twelve 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 C1505, C0922, and N1105 for details.

An investigation specific to assessments.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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 By Pam Anderson

Julie Edmiaston RN, BSN

Mary Cooper RN

Date report completed: 12/02/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **Oklahoma City, Okla. 73120**
Provider #: **AL5523**
Complaint #: **OK00055961**
Investigation Date(s): **November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to assess residents with significant change to determine proper placement/change in resident services/contract.	S

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 12/16/2021 at 10:30 a.m.

A sample of 3 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 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 C0522 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 . 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.

Mary Cooper By Pam Arden

Mary Cooper RN

Date report completed: 12/03/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **Oklahoma City, 73120**
Provider #: **AL5523**
Complaint #: **OK00056360**
Investigation Date(s):November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to report an allegation of misappropriation/failed to have or follow their grievance procedure.	S

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

An unannounced on-site investigation was initiated on 11/16/2021 at 10:30 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 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 C1911 for details.

An investigation specific to incident reports, contracts, and investigations related to misappropriation of property was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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 By Pam Arkeen

Julie Edmiaston RN, BSN

Mary Cooper RN

Date report completed: 12/02/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **Oklahoma City, Okla. 73120**
Provider #: **AL5523**
Complaint #: **OK00057905**
Investigation Date(s): **November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate medical care.	S

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 11/16/2021 at 10:30 a.m.

A sample of 4 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 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 C1505, N1425 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 . 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.

Mary Cooper By Pam Ardeen

Mary Cooper RN

Date report completed: 12/03/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **Oklahoma City, Okla. 73120**
Provider #: **AL5523**
Complaint #: **OK00057961**
Investigation Date(s): **November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to do proper discharge planning and notification.	S

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 11/16/2021 at 10:30 a.m.

A sample of 3 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 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 C0350 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 . 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.

Mary Cooper Kay Pam Anderson

Mary Cooper RN

Date report completed: 12/03/2021

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 #: **OK00057977**
Investigation Date(s): **November 16th-18th, 22nd-24th and December 2nd, 3rd, 6th, and 7th/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were properly administered.	S

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

An unannounced on-site investigation was initiated on 11/16/2021 at 10:30 a.m.

A sample of twelve 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 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 C1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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 RN, BSN

Mary Cooper RN

Date report completed: 12/02/2021

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 #: **OK00058085**
Investigation Date(s) **December 2nd, 3rd, 6th, and 7th/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate and sufficient staff to meet the needs of the residents.	S

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

An unannounced on-site investigation was initiated on 12/02/2021 at 8:15 a.m.

A sample of five 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 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 C1505, C0961, C1304 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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.

Mary Cooper By Pam Andrasek

Mary Cooper RN

Date report completed: 12/09/2021

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 _____	C 12/07/2021

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
N 000	Initial Comments A relicensure survey was conducted from 11/16/21 through 11/18/21 and 11/22/21 through 11/24/21. Additionally, 12/02/21, 12/03/21, 12/06/21, and 12/07/21. Complaint investigations (#OK00057977, OK00057961, OK00057905, OK00056360, OK00055961, and #OK00055906, OK00055861, OK00055886, OK00055842, OK00055204, OK00058085) were conducted in addition to the survey. The Executive Director identified 152 residents resided in the center. Listed below are abbreviations that will be used throughout this document. ABD pad-Highly absorbent dressing ABD-Abdomen ACMA-Advanced Certified Medication Aide ADL's- Activity of Daily Living AED-Assistant Executive Director BKA-Below knee amputee BPH-Benign Prostate Hypertrophy CBC- Complete Blood Count CHF-Congestive Heart Failure CMA-Certified Medication Aide CMP-Comprehensive Metabolic Panel CPR-Cardiopulmonary resuscitation DM-Diabetes Mellitus D/T-Due to FSBS-Finger stick blood sugar GERD-Gastroesophageal Reflux Disease HbA1c-Hemoglobin A1c (lab for blood glucose) LEC-Life Enrichment Coordinator LPN-Licensed Practical Nurse LTCA-Long Term Care Aide MAR-Medication Administration Record MAT-Medication Administration Technician MG- Milligrams	N 000		

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N 000	Continued From page 1 MG/DL-Millgrams per Deciliter MCG-Micrograms OSDH-Oklahoma State Department of Health OTC-Over the Counter PT/OT-Physical Therapy/Occupational Therapy Res-Resident RN-Registered Nurse STAT-Immediately TAR-Treatment Administration Record VA-Veteran's Administraton	N 000		
N1105 SS=E	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:	N1105		

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N1105	Continued From page 2 a) complete a performance review for every nurse aide at least once every twelve months for six (#18, 25, 39, 52, 58, and #62) of seven sampled LTCA's employed by the center for at least 12 months, and b) ensure that each nurse aide certification is current and not expired for seven (#22, 44, 50, 56, 57, 59, and #62) of 28 sampled LTCA's employed by the center. Findings: The "Medication Administration" policy, not dated, read in part, "...Any/all staff administering medications will have documentation of training as outlined per state regulatory guidelines in their individual employee file..." On 11/16/21 at 2:17 p.m., the human resource employee was asked to submit staffing credentials to include certificates, skills check off, licensure, and criminal background checks. On 11/23/21 at 3:00 p.m., the human resource employee was asked about the LTCA's listed above. She stated she did not find their skills check off or their LTCA certificates. LTCA #18 hired 01/28/19 LTCA #25 hired 07/05/17 LTCA #39 hired 07/10/20 LTCA #52 hired 10/16/20 LTCA #58 hired 10/17/19 LTCA #62 hired 10/07/20	N1105		
N1425 SS=E	310:677-13-7 (b) (1) Skills And Functions Limitations. A certified medication aide shall not:	N1425		

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N1425	Continued From page 3 (1) Administer medication that requires assessment unless a registered nurse is available to perform the assessment within the required time; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the center failed to ensure qualified staff performed wound care for one (#17) of four sampled residents reviewed for wound care. Findings:	N1425		

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N1425	Continued From page 4 Res #17 was admitted with diagnoses which included hypertension, hyperlipidemia, type II insulin dependent diabetes, and depressive disorder. A "Physician Order" dated 10/19/21, read in part, "...Clean Lower ABD daily with soap and water, pat dry, apply santyl and a vashe soaked gauze change daily one time a day for wound care..." On 11/17/21, the center provided a list of residents who resided in the memory care unit which identified three residents with wounds. Res #17 was not identified on the list as having a wound. On 11/24/21 at 9:45 a.m., Res #17's wound was observed. The wound was on the lower left quad of the abdomen. A border gauze dressing was intact, dated 11/22/21. Res #17 removed their dressing and no redness or odor was noted. There was a scant amount of drainage on the dressing. The resident was asked who changed her dressing and she reported LPN #4, but stated he had missed the dressing change the previous day. At 10:10 a.m., ACMA #13 was asked if she changed the dressing as documented on 11/23/21. She stated, "no, the resident refused." The ACMA stated she told LPN #4 and he said he would do it. She was asked if she normally changed the dressing. She stated, "That one I was told we could do because it's a cream." She acknowledged her initials were on the TAR which documented she had completed dressing changes on November 13th, 14th, 15th, 20th, 21st and 23rd, 2021. At 10:22 a.m., ACMA #15 was asked if she had	N1425		

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N1425	Continued From page 5 documented that she performed dressing changes for Res #17 on 11/2/21-11/05/21, 11/10/21-11/12/21, and 11/16/21, 11/18/21, 11/19/21 and 11/22/21. She stated, "yes." She was asked if she was certified to do dressing changes and if the center's policy allowed her to do dressing changes. The ACMA stated, "I do not know, we do not have a nurse back here." At 10:53 a.m., LPN #8 was asked if ACMAs were allowed to do dressing changes with wound care. She stated she didn't think so but didn't know for sure. The LPN reported to her knowledge, the ACMAs did not do wound care. She described Santyl as a debrider for wounds. The TAR was reviewed with the LPN and she was asked if the initials documented on the TAR indicated wound care was performed by nurses. The LPN stated, "No."	N1425		
C 000	INITIAL COMMENTS A relicensure survey was conducted from 11/16/21 through 11/18/21 and 11/22/21 through 11/24/21. Additionally, 12/02/21, 12/03/21, 12/06/21, and 12/07/21. Complaint investigations (#OK00057977, OK00057961, OK00057905, OK00056360, OK00055961, and #OK00055906, OK00055861, OK00055886, OK00055842, OK00055204, OK00058085) were conducted in addition to the survey. The Executive Director identified 152 residents resided in the center. Listed below are abbreviations that will be used throughout this document. ABD pad-Highly absorbent dressing	C 000		

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C 000	Continued From page 6	C 000		

ABD-Abdomen
ACMA-Advanced Certified Medication Aide
ADL's-Activities of Daily Living
ADON-Assistant Director of Nursing
AED-Assistant Executive Director
BKA-Below Knee Amputation
BPH-Benign Prostatic Hyperplasia
CBC-Complete Blood Count
C-Diff-Clostridium Difficile
CMA-Certified Medication Aide
CMP-Comprehensive Metabolic Panel
CHF-Congestive Heart Failur
C/O-Complains of
CPR-Cardiopulmonary resuscitation
DM-Diabetes Mellitus
D/T-due to
FSBS-Fingerstick Blood Sugar
GERD-Gastroesophageal Reflux Disease
HbA1c-Hemoglobin A1c (lab for blood glucose)
HWD-Health and Wellness Director
LEC-Life Enrichment Coordinator
LPN-Licensed Practical Nurse
LTCA-Long Term Care Aide
MAR-Medication Administration Record
MAT-Medication Administration Technician
MCG-Micrograms
MG-Milligrams
MG/DL-Milligrams per Deciliter
OSDH-Oklahoma State Department of Health
OTC-Over The Counter
POA-Power of Attorney
PT/OT-Physical Therapy/Occupational Therapy
Rep-Representative
Res-Resident
ROM-Range of Motion
RN-Registered Nurse
STAT-Immediately
TAR-Treatment Administration Record
VA-Veterans Administration

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C 350	Continued From page 7	C 350		
C 350 SS=D	310:663-3-5(a)(1-2) INVOLUNTARY TERMINATION (a) If an assisted living center finds pursuant to 310:663-3-4 (relating to appropriate placement) that a resident is inappropriately placed, the assisted living center shall inform the resident and/or the resident's representative if any. If voluntary termination of residency is not arranged, the assisted living center shall provide written notice to the resident and to the resident's representative, giving the resident thirty (30) days notice of the assisted living center's intent to terminate the residency agreement and move the resident to an appropriate care provider. The (30) day requirement shall not apply: (1) when emergency termination of the residency agreement is mandated by the resident's immediate health needs; or (2) when the termination of the residency agreement is necessary for the physical safety of the resident or other residents. This Rule is not met as evidenced by: Based on interview and record review, the center failed to provide a discharge notification for one (#2) of two sampled residents who discharged	C 350		

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C 350	Continued From page 8 from the center. A Center "Policy and Procedure" read in part, "...Discharge of Resident... Procedure: Residents may not be asked to move from the community without appropriate written notice as outlined per state regulations except in circumstances where undue delay might jeopardize the life, health or well being of the resident involved or other resident or staff. Reasons for need to discharge must be documented in the resident file. Prior to notice, and to avoid notice of discharge through intervention, whenever possible a meeting should be held with family/ legal rep to coordinate and plan for a resident move. All residents/families/responsible parties/ legal authorities shall, at the time of the move be given a final accounting statement..." Findings: Res #2 was admitted with diagnoses which included, rheumatoid arthritis, hyperlipidemia, BPH, CHF, and edema. Res #2's, "Resident Service Contract", dated April 26, 2016, read in part, "...II. Resident/Responsible Party's Responsibilities...H. Relocation From the Community Contract services: Discharge criteria: The Community is not a skilled nursing facility and may not administer complex nursing care requiring 24 hour supervision. In the event the community or the state agencies determined that the residents care need exceed that which the community is licensed to provide the responsible party agrees to initiate the transfer of the resident within five working days following receipt of written notification of intent to discharge. Progress of the transfer shall be noted in the residents records..."	C 350		

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C 350	Continued From page 9 Res #2's "Service plan", dated 07/5/19, read in part " Resident used an electric scooter, required transfer assistance with transfer either physical or verbal cueing. Requires staff to assist with dressing each morning. Requires total assistance with grooming, lotion, nails or extended care. Judgement good, sound decisions. Safety: requires assist of one to evacuate..." Res #2's "Assessment Form" dated 09/22/20, read in part, "...Mobility, Strength and Gait as P=Poor...Ambulatory with staff assistance, had to be assisted with transfers and if using manual wheelchair..." A "Progress Note" read in part, "...10/19/21 13:34 [1:34p.m.] Late entry: On or before 10/19/21 Resident was transferred to the hospital for diarrhea and vomiting..." A "Progress Note" read in part, "...10/22/2021 13:42 [1:42 p.m.] Resident [POA] was called to discuss the need to have resident transferred to long term Care d/t 2 person assist [POA] was very receptive of this he stated that he knew the time was coming because Res #2 is total dependent for all ADL's and he has become very weak and unable to help with any of his personal needs. [POA] is in progress of looking for long term care for him. The ED and the person documenting on this gave several names of different facilities to check on." On 11/17/21 at 3:34 p.m., the Executive Director was asked if the facility provided transportation back to the center when Res #2 was discharged from the hospital on 10/25/21. She replied, yes. She was asked what happened when Res #2 arrived to the center. She replied she notified the	C 350		

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C 350	Continued From page 10	C 350		

discharge case manager at the hospital and informed her the resident had arrived and we are not taking him back. The executive director informed her the hospital could not send him back to the center with active diarrhea. She was asked if the center was equipped to care for someone with C-diff. She replied, he is a two person assist.

At 3:40 p.m., the Executive Director was asked if Res #2 had been discharged from the center. She stated,"No, it was kind of a mutual agreement." She was asked if she ever asked Res #2 to discharge and why was the resident not allowed back to the center when he returned on 10/25/21. She stated because he had C-Diff and he was a two person assist.

On 11/18/21 at 8:29 a.m., employee #12 was asked if he transported Res #2 back to the center on 10/25/2021. He replied, he met the family at the hospital, loaded the resident and transported him back. He said he received a text from the center sometime during the transport that instructed him not to bring the resident back to the center however, he did not see the text until sometime later. As he assisted Res #2 down the ramp on the van, employee #11 told him, "Don't bring him inside." Res #2 was transferred back to the hospital via the transport van.

At 10:12 p.m., employee #11 was asked to describe what happened when Res #2 arrived to the center. She stated, " My phone rings, it's the [Executive Director], we had been sent to go get [Res #2]. I told her they are just pulling up, [Executive Director] stated, "Do not let him off that van." I informed the [family members] that he was suppose to go back to the hospital.

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C 350	Continued From page 11 At 11:35 a.m., the Executive Director was asked if Res #2 was discharged from the center. She stated, "We didn't discharge him. I think MAT #16 discharged him out of the computer on 11/16/21." She was asked how did she know Res #2 was not returning to the center. She stated, "Honestly I saw a note on file he moved to [another center]." At 1:47 p.m., Resident #10 (Res #2's) family member was interviewed and stated the resident required two person assistance with a slide board for transfers. Resident #10 became tearful and stated the last time she was able to see Res #2 was the night he was sent to the hospital. On 11/22/21 at 9:08 a.m., Res #2's POA stated, "On Friday the 22nd {November 22, 21} the center called me out of the blue, basically he was going to be evicted." He was asked if he was agreeable to Res #2 being discharged. He replied, he did not think he had a choice. Res #2's POA was asked prior to 10/22/2021 had there been any discussion about needing to look for another center. He replied, no. He was asked if he received any written notification of discharge from the center. He stated, "No." At 3:42 p.m., MAT #16 was asked to review the progress note entered by her on 10/22/21 regarding the conversation with the family about moving Res #2. She replied, she did not remember that conversation. No documentation was in the clinical record of a voluntary or involuntary discharge at the time of survey.	C 350		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES	C 522		

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C 522	Continued From page 12 (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 interview and record review the center failed to, a) Complete comprehensive assessments for two (#2, and #10) of 13 sampled residents for annual comprehensive assessments, and b) Complete a significant change assessment for one (#5) of two sampled residents for significant change assessments. Findings: 1) Res #2 was admitted with diagnoses which included, rheumatoid arthritis, hyperlipidemia, BPH, CHF, and edema. On 11/22/21 at 3:42 p.m., an "annual assessment" dated 09/22/2020, was reviewed with MAT #16. She acknowledged there was no annual assessment completed for 2021. 2) Res #5 was admitted with diagnoses which included, hypertension Parkinson's disease, GERD, and anxiety disorder.	C 522		

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C 522	Continued From page 13 An "annual assessment", dated 04/17/2020, documented, "...Res #5 was independent with ADL's, had full ROM, ambulated without assistance , and mobility, strength and gait was good..." An "Incident Note", dated 07/15/2020, documented, "...Resident found on the floor in apartment beside recliner. No apparent injury noted at this time. Assist resident from floor with help from another staff. Resident was able to ambulate self to bed. Pain level 4/10 on lower back..." A "Behavior Note", dated 07/22/2020, documented, "...Checked on resident. Resident was sitting in her recliner with [family member] in the room. Resident have [sic] a broken back and is unable to do ADL's on her own. The [family member] say they are getting help with a sitter to be with the resident. Resident continues to be checked on every two hours..." On 11/24/2021 at 11:04 a.m., LPN #8 was asked if an assessment should have been done to reassess residents abilities and need for increased assistance. She replied, yes. LPN #8 acknowledged a significant change assessment was not completed at the time. 3) Res #10 was admitted with diagnoses which included, gout, generalized anxiety disorder, and atherosclerotic heart disease. On 11/24/21 at 11:10 a.m., an "annual assessment", dated 09/22/2020, was reviewed with LPN #8. She acknowledged there was no annual assessment completed for 2021.	C 522		

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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
C 542	Continued From page 14	C 542		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a comprehensive assessment was coordinated and/or signed by an RN and/or physician for seven (#1, 2, 3, 4, 6, 7, and #17) of 10 sampled residents. Findings: 1. Res #1 diagnoses included essential hypertension, chronic atrial fibrillation, and hypothyroidism. An "Annual Assessment," dated 10/25/21, documented no signature to indicate it was coordinated with a RN or physician. On 11/23/21 at 11:36 a.m., LPN #8 was asked if Res #1's assessment contained signatures from the RN and/or physician. She stated the assessment had no signatures. 2. Res #4 diagnoses included autistic disorder, developmental disorder of speech/language. An "Annual Assessment," dated 11/10/21, documented no signature to indicate it was coordinated with a RN or physician. On 11/23/21 at 11:20 a.m., LPN #8 was asked if Res #4's assessment contained signatures from the RN and/or physician. She stated no.	C 542		