

Delivery via email to: sarah@quailridgeassistedliving.com; shamela.armour@gmail.com;
gpastrana@quailridgeassistedliving.com

March 18, 2022

License Number: AL5523

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

RE: Survey Events MLOE12 & 9V2111

Dear Ms. Bagby:

Enclosed is the Assisted Living Center Licensure inspection deficiency report form, showing the summary of deficiencies noted during the revisit at your facility on **March 8, 2022** and your complaint investigation on **March 8, 2022**. These deficiencies remain uncorrected since your survey of **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 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,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.03.18 15:35:23 -05'00'

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

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Quail Ridge Senior Living
Address: 12401 Trail Oaks Drive
City, State, Zip: Oklahoma City, OK 73120
Provider #: AL5523
Complaint #: OK00058478
Investigation Date(s): 02/25/22, 02/28/22 through 03/04/22, 03/07/22 and 03/08/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The Center failed to notify OSDH of changes in administration as required by state regulation.	S
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 02/25/2022 at 11:15 a.m.

A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C 0930 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.

Ed Roth signed by Zesh Collins, Pres.

Ed Roth Preventative Medical Consultant

Date report completed: 03/11/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Quail Ridge Senior Living
Address: 12401 Trail Oaks Drive
City, State, Zip: Oklahoma City, OK 73120
Provider #: AL5523
Complaint #: OK00058444
Investigation Date(s): 02/25/22, 02/28/22 through 03/04/22, 03/07/22 and 03/08/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to have and/or implement their abuse policy.	US
2. The center failed to ensure medications were properly administered.	S
3. The center failed to ensure required documentation was complete and accurate.	S
4. The center failed to have required staff.	S

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

An unannounced on-site investigation was initiated on 02/25/2022 at 11:15 a.m.

A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

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

An investigation specific to criminal background checks was conducted. The OK Screen records were reviewed for previous employees and employees after 12/07/21. No residents had complaints about staff. The business office manager stated they were processed accordingly. During the survey, there was no deficient practice related to criminal background checks.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C 1505 and Tag C 1922 for details.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C 1951 for details.

Allegation #4: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C 0921 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2, 3, and #4. 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 #1. No further action is required.

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

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script, reading "Melissa Swaim RN", written over a horizontal line.

Melissa Swaim RN

Date report completed: 03/10/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Quail Ridge Senior Living
Address: 12401 Trail Oaks Drive
City, State, Zip: Oklahoma City, OK 73120
Provider #: AL5523
Complaint #: #OK00058443
Investigation Date(s): 02/25/22, 02/28/22 through 03/04/22, 03/07/22 and 03/08/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered as ordered.	S
2. The center failed to ensure residents could voice grievances without fear of retaliation.	US

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

An unannounced on-site investigation was initiated on 02/25/2022 at 11:15 a.m.

A sample of seventeen 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.

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

An investigation specific to resident grievances without fear of retaliation was investigated.

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed on all three floors, during meal times, while receiving personal care, and during medication administration.

During survey, an Ombudsman was observed visiting with residents behind the main dining area in a room across from the memory care unit. A suggestion box for anonymous complaints was visible for resident/family/responsible party/legal authority, staff and general public in an accessible and visible location near the bistro. The complaint procedure and resident rights were posted at the center.

The center's assigned interim Executive Director/Designee was at the center at the time of survey. The complaint procedure and the Ombudsman information was posted at the center in an area visible to the residents. The Ombudsman information outlined the purpose of the program was to improve the quality of life and quality of care of residents. Residents interviewed either denied concerns at the center or reported they had notified the former Executive Director and/or various other staff members. One resident when asked about the grievance procedure, stated it would depend on the area of concern. She stated she had spoken to the kitchen staff in the past about the food. She stated she had made concerns about the noise level, known to the former Executive Director, but she was no longer employed at the center. She stated the noise was no longer an issue and denied any retaliation for making a grievance. Phone interviews were conducted with the Ombudsman who was present on the day of survey. Phone interviews were conducted with contracted personnel in response to grievances and/or meetings conducted for known concerns related to medication administration.

The center's grievance policy and procedure were reviewed. The center provided future contracts for two Administrators, one to start on March 14, 2022 and the other to start on March 28, 2022. The residents' individual residential contracts outlined the center's grievance procedure and outlined if the complaint was not handled in a manner deemed satisfactory by the resident, they may contact the Oklahoma Department of Health Services. At the time of the investigation, there was no deficient practice related to retaliation for filing and/or expressing grievances.

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 Digitally signed by Julie Edmiaston
Date: 2022.03.15 18:17:49 -05'00'

Julie Edmiaston RN, BSN

Date report completed: 03/08/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Quail Ridge Senior Living
Address: 12401 Trail Oaks Drive
City, State, Zip: Oklahoma City, OK 73120
Provider #: AL5523
Complaint #: OK00058233
Investigation Date(s): 02/25/22, 02/28/22 through 03/04/22, 03/07/22 and 03/08/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to have adequate staff.	S
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 02/25/2022 at 11:15 a.m.

A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

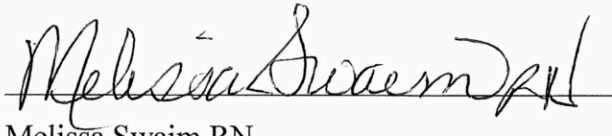
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C 1505 for details.

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.

A handwritten signature in black ink, appearing to read "Melissa Swaim RN", written over a horizontal line.

Melissa Swaim RN

Date report completed: 03/10/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER QUAIL RIDGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS Complaint investigations (#OK00058233, OK00058443, OK00058444, and #OK00058478) were conducted 02/25/22, 02/28/22 through 03/04/22, 03/07/22 and 03/08/22. Listed below are abbreviations that will be used throughout this document. ACMA-Advanced Certified Medication Aide\ AREDS-Age Related Eye Disease Supplement BOM-Business Office Manager CMA-Certified Medication Aide ED-Executive Director ER-extended release FSBS-Finger Stick Blood Sugar F/U-Follow up HR-Human Resources LPN/DON-Licensed Practical Nurse/Director of Nursing MAR's-Medication Administration Records MEQ- Milliequivalents MG-Milligrams Res-Resident RN-Registered Nurse TAR-Treatment Administration Record	C 000		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist.	C 921		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER QUAIL RIDGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 921	Continued From page 1 This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to perform medication reviews by the RN or pharmacy consultant at least monthly. The interim Executive Director identified 148 residents who resided at the center. Findings: The "RN Consulting Services Agreement," dated 01/20/22, read in parts, "...This Consulting & Retainer Agreement is made effective as of January 20, 2022, by and between an individual known as (name-deleted) RN...and a business entity known as (name-deleted) Assisted Living..." On 03/01/22 at 12:08 p.m., LPN/DON #8 was asked about the center's RN coverage. Staff member # 8 reported the center contracted with a RN on 01/20/22. Staff member # 8 was asked if the RN had performed the residents' monthly medication reviews; and stated no. Staff member # 8 was asked how often the pharmacy consultant visited the center; and stated the last time was February 2022 and it was around October 2021 prior to that.	C 921		
C 930 SS=E	310:663-9-3(1-3) STAFF QUALIFICATIONS Each assisted living center shall designate an administrator responsible for the operation of the assisted living center. The administrator shall hold at least one (1) of the following credentials: (1) a license issued by the State Board of Examiners for Nursing Home Administrators; or (2) a residential care home administrator's	C 930		

Oklahoma State Department of Health

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C 930	Continued From page 2 certificate of training from an institution of higher learning whose program has been reviewed by the Department; or (3) a nationally recognized assisted living certificate of training and competency for assisted living administrators that has been reviewed and approved by the Department. This Rule is not met as evidenced by: Based on record review and interviews, the center failed to have a licensed administrator responsible for the operations of the center. The interim Executive Director identified 148 residents resided at the center. Findings: A letter of acceptance for job, dated 02/21/22, read in part, "...Please be informed that we are appointing you as the acting Manager of Operations of Quail Ridge Assisted Living until the position is filled. This is effective 02/16/22..." The letter was signed by the Business Office Manager and the Corporate Operations Director. The position was then acknowledged with a signature by the Assistant Executive director/food and beverage manager of the center. On 02/25/22 at 11:20 a.m., the interim Executive Director (Staff #2) stated they were appointed in	C 930		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/08/2022
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C 930	Continued From page 3 charge of the center on 02/16/22 and was not a licensed administrator. On 03/07/22 at 2:45 p.m., the corporate consultant for sales and operations was asked who was in charge of the center; and stated that Staff #2 was appointed the interim Executive Director and was not aware that Staff #2 was not a licensed administrator.	C 930		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/08/2022
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C1505	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to: a) follow physicians order for monitoring and management of glucose for one (#17) of three sampled residents reviewed for glucose monitoring; b) administer medications as ordered by the physician for one (#1) of five sampled residents reviewed for medication administration; and c) administer medications as ordered by the physician for three (#24, 30, and #31) of three sampled residents reviewed for timeliness of medication administration. The interim Executive Director identified 148 residents who resided at the center. Findings: 1. Resident (Res) #17 had diagnoses which included diabetes mellitus type two. A care plan with no date for insulin administration, read in part, " ...Nursing staff does blood sugar checks. Nursing provides insulin	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 5 administration..." A current Physician's Order, dated March 2022, documented to administer Novolog according to the sliding scale. The order documented to administer 10 units of Novolog for a FSBS reading of 350 or greater, recheck the FSBS in two hours, and if the FSBS reading remained greater than 350 notify the physician. The TAR for Res #17, dated 02/01/22 - 02/28/22, documented the resident had elevated blood sugars on the following dates and times: 02/05/22 - 7:00 a.m. 600; 11:00 a.m. 397; and 5:00 p.m. 399; 02/06/22 - 7:00 a.m. 600; and 11:00 a.m. 359; 02/07/22 - 7:00 a.m. 361; 11:00 a.m. 405; and 5:00 p.m. 409; 02/09/22 - 7:00 a.m. 401; and 11:00 a.m. 361; 02/11/22 - 7:00 a.m. 523; and 5:00 p.m. 524. A review of the clinical record contained no documentation to indicate the resident's blood sugar was rechecked after two hours when the FSBS readings were greater than 350 and/or if the physician had been notified of elevated blood sugars. On 03/02/22 at 2:21 p.m., LPN/DON #8 was asked about the blood sugar monitoring of Res #17; and stated that when Res #17's blood sugar was elevated greater than 350, the staff was to administer 10 units of insulin and recheck the	C1505		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER QUAIL RIDGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120		
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C1505	Continued From page 6 blood sugar. The LPN/DON #8 stated if after two hours if the FSBS reading was 350 or greater the physician would need to be notified. LPN/DON #8 reviewed the February 2022 TAR; and was asked about the elevated FSBS readings and if the facility followed the physician's orders regarding glucose monitoring and physician notification on 02/05/22, 02/06/22, 02/07/22, 02/09/22, and 02/11/22. She stated she would have to look at the records. On 03/02/22 at 3:15 p.m., the LPN/DON #8 stated there was not any documentation for Res #17 blood sugar readings were rechecked after two hours and/or the physician had been notified of the continual elevated FSBS readings. 2. An "Assessment," dated 06/01/21, read in parts, "...diagnoses to include essential hypertension and chronic atrial fibrillation. Alert, forgetful with good judgment..." A "Physician's Order," dated 01/05/22, read in parts, "...In preparation for her upcoming dental procedures, please administer Clindamycin 150 mg three times per day for seven days with food, starting immediately, for dental infection..." A "Physician's Order," dated 02/28/22, read in parts, "... Levothyroxine Sodium tablet 100 mcg give 1 tablet by mouth in the morning for hypothyroidism...Nexium capsule delayed release 40 mg give 1 capsule by mouth one time a day related to GERD..." On 02/28/22 at 3:45 p.m., Res #1 was interviewed and reported various days her medications were delivered late after 10:00 a.m.	C1505		

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C1505	Continued From page 7 A "MAR," dated January 2022, documented, staff initials were missing from six doses of Clindamycin. There were not staff initials for six of the twenty-one scheduled doses of Clindamycin. Res #1's, "Progress Note," dated 02/06/22 at 08:50 a.m., stated, "... CMA went to administer residents 06:00 medication, but the resident door was locked. This nurse tried all attempts to unlock the door but was unsuccessful. Notified Executive Director. It appears the said key has been removed from the bundle of keys. Will f/u with previous shift where the keys are kept. Resident eventually opened her door and medication was administered at 06:50..." The 06:00 a.m., medication was not initialed by the CMA to indicate it was administered on the MAR; however, the progress note indicated the medication was administered on 02/06/22. LPN #91 (charge nurse on 02/06/22) signature was on the progress note. A staff schedule, dated 02/06/22, documented, LPN #91 was scheduled as the LPN in charge and CMA #38 was scheduled for the North building and for the 1st floor on the assisted living side. On 03/02/22 at 2:20 p.m., notified LPN #91 via telephone who works on the night shift; was asked if she administered medications on the night shift. LPN #91 stated she only administered medications on the night shift if the center was shorthanded. This nurse stated if the center was fully staffed, and did not administer medications. LPN #91 was asked why Res #1 did not receive her 06:00 a.m., medications on February 6th, 7th,	C1505		

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C1505	Continued From page 8 or 8th; and stated it would have been a CMA scheduled to administer the medications. LPN #91 was not informed Res #1 had not received her medications. On 03/07/22 at 12:20 p.m., LPN/DON #8 was asked to review the electronic record for Res #1. This nurse was asked how many doses of Clindamycin was not initialed by the staff; and stated six. This nurse was asked about documentation in the record to explain why staff did not administer Res #1's medications on February 6th, 7th, and 8th, 2022. LPN/DON #8 identified the one progress note dated 02/06/22 and stated "That's the only thing I see." 3. Res #24's MAR, dated 03/07/22, read in part, "...7:00 a.m. - 9:00 a.m., amiodarone for essential hypertension, hydrochlorothiazide for essential hypertension, and meloxicam for pain..." 4. Res #30's MAR, dated 03/07/22, read in part, "...8:00 a.m., amlodipine besylate for hypertension, duloxetine hcl for depression, lamotrigine for seizure..." 5. Res #31's MAR, dated 03/07/22, read in part, "...7:00 a.m. - 9:00 a.m., sertraline hcl for depression, memantine hcl for memory, aspirin for atrial fibrillation, lasix for edema, and lisinopril for essential hypertension..." On 03/07/22 at 10:14 a.m., LPN #3 was observed passing medications on hall 200; and stated medication pass just started and the medications were going to be late. At 10:25 a.m., Res #31 asked LPN #3 about getting his medications; and stated they were late.	C1505		

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C1505	Continued From page 9 At 10:36 a.m., LPN/DON #8 was asked about the late medications; and stated the medication aide called in and did not get the message until 8:00 a.m. At 10:55 a.m., during observation of the medication pass, Res #24, Res #30, and Res #31 were all observed receiving their medications late. At 11:20 a.m., LPN #3 stated the interim ED was told at about 9:15 a.m., the medication aide was not coming in and got on the medication cart as soon as possible. This nurse stated medications passed late to nine residents and still had the other half of the hall to pass. At 2:39 p.m., LPN #3 stated passed medications late this morning and stated the last morning medication was given at 12:30 p.m. This nurse stated morning medications could not be administered until after the FSBS were completed. LPN #3 identified sixteen residents who resided on hall 200 had not received their morning medications on time.	C1505		
C1922 SS=D	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on observation, record review, and	C1922		

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C1922	Continued From page 10 interview, the center's medication administration staff failed to observe a resident swallowing medications for one (#26) of four sampled residents observed for medication administration on the third floor. The interim Executive Director identified 148 residents who resided at the center. Findings: Res #26 had diagnoses which included edema, congenital stenosis of aortic valve, and hypertension. A list provided on 02/25/22 from the LPN/DON #8 listed 22 residents who were able to self-administer medications. Res #26 was not on the list the LPN/DON #8 provided. Res #26's clinical record contained no documentation the resident had been assessed for or was able to self-administer medications. Res #26 current physician's orders and MAR for March 2022 documented the resident was to be administered the following medications at 7:00 a.m.: potassium chloride ER 10 MEQ; furosemide 20 mg; clopidogrel bisulfate 75 mg; losartan potassium-HCTZ 50-12.5 mg; and metoprolol tartrate 25 mg. On 03/01/22 at 7:54 a.m., ACMA #92 was observed passing medications on the third floor of the facility. At 8:19 a.m., Res #26 stated they was	C1922		

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C1922	Continued From page 11 administered five pills every morning; and did not want to take medications this morning when ACMA #92 brought them. This Res #26 stated the ACMA left them in room to take later. Res #26 was observed with a medication cup containing five pills. Res #26 identified the medication as morning medication, left by ACMA #92. At 3:00 p.m., ACMA #92 was asked if anyone on her floor that was able to self-administer medications; and did not identify Res #26. ACMA #92 stated Res #26's medication were left in room and did not observe the resident swallow the medication. On 03/02/22 at 10:13 a.m., the LPN/DON #8 was asked what the criteria was for self-administering medications. The LPN/DON #8 stated the resident would be evaluated by the doctor and the facility staff on admission to determine if the resident was capable of administering their medications without the help of staff. At 2:10 p.m., the LPN/DON #8 stated Res #26 was never assessed to determine if they could self-administer their medication. The LPN/DON #8 was made aware of the medications left in the room; and stated the medications should not have been left in the room.	C1922		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include:	C1923		

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C1923	Continued From page 12 (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to maintain documentation to include the title of the staff who administered and/or assist residents with medications. The interim Executive Director identified 148 residents who resided at the center. Findings: A "Signature List," dated March 1, 2022, documented five staff member names with corresponding titles. The other 47 staff members did not have titles listed. The center's MARs did not identify the titles of the staff members who administered medications. On 03/01/22 at 12:10 p.m., LPN/DON #8 was asked to submit the signature page for staff to	C1923		

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C1923	Continued From page 13 include titles who administered medications at the center; and stated the list did not include the titles of the staff members who administered medications. This nurse stated it might be something HR could obtain.	C1923		
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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to: a) place Coumadin [blood thinner medication] on hold as physician ordered and complete an accurate assessment to include the assessment date for one (#1) of four sampled residents reviewed for anticoagulant therapy and 13 sampled residents reviewed for assessments; b) obtain a clarification of a physician's order for Coumadin for one (#9) of four sampled residents reviewed for PT/INR monitoring; c) make sure the self-administration evaluations were up-to-date and physician's orders matched the medications administered for two (#22 and #32) of two sampled residents reviewed for self-administration of medications; and d) obtain physicians order for two (#28 and #29) of two sampled residents reviewed for safety and	C1951		

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C1951	Continued From page 14 supervision. The interim Executive Director identified 148 residents who resided at the center. Findings: 1. Res #1's "Annual Assessment," dated 01/05/21 [sic], read in parts, "...alert times 4 with good judgment..." This assessment was signed by a participating health professional on 01/07/22 and dated by the RN on 02/20/21 [sic]. Res #1's "Assessment," dated 06/01/21, read in parts, "...diagnoses...essential hypertension and chronic atrial fibrillation. Alert, forgetful, good judgment..." A "Physician's Order," dated 02/10/22, read in parts, " ...Please also cease administration of Coumadin 48 hours prior to next dental surgery appointment...Res #1 is scheduled on February 25th (2022) at 8:00 a.m..." A MAR, dated February 2022, read in parts, "...Warfarin 2.5 mg give one tablet by mouth one time a day related to chronic Atrial Fibrillation, DC (Discontinue) Date: 02/23/22 @09:49..." The medication was initialed by ACMA #6 as if it had been administered on 02/23/22 at 07:00 AM. On 02/25/22 at 11:15 a.m., the center was asked to submit a list of residents with PT/INR monitoring. Resident #1 was not identified on the list. On 02/28/22 at 3:45 p.m., Res #1 was interviewed and reported the physician had informed not to take Coumadin and had submitted the physicians order to the nurse. This	C1951		

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C1951	Continued From page 15 resident reported they knew not to take the Coumadin and did not take it. On 03/01/22 at 08:50 a.m., LPN/DON #8 was asked about the date on Res #1's assessment; and stated the dates on the assessment were inaccurate it should be 01/05/22. This nurse was asked about the blanks on the front page of Res #1's assessment; and stated, "Should say see attached." At 2:00 p.m., ACMA #6 was asked about Res #1's Coumadin; and stated they went to administer Res #1's Coumadin on the morning of 02/23/22 and the resident informed they were not to take Coumadin. ACMA # 6 stated they called LPN #3. ACMA #6 was asked if they administered the Coumadin to Res #1; and stated they did not administer the medication to Res #1. At 2:05 p.m., LPN #3 was asked why the Coumadin was not on hold for Res #1; and stated the Coumadin was place on hold in the computer. This nurse stated it popped up on the computer to be administered when ACMA #6 was administering medications. LPN #3 stated the computer did not allow the medication to be placed on hold and had to go back into the computer and actually discontinue the medication and restart the medication on 02/26/22. 2. Res #9 diagnoses included essential hypertension, atrial fibrillation and flutter, and diverticulosis of intestine, part unspecified, without perforation of abscess with bleeding. A "Physician's Order," dated 01/20/22, read in parts, "...INR result 3.6. Please adjust Warfarin (Coumadin) as follows: Fri 1/21=0 mg, Sat 1/22=0 mg, Sun 1/23=4 mg, Mon 1/24=4 mg,	C1951		

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C1951	Continued From page 16 Tues 1/25=4 mg, Wed 1/26=4 mg, Thurs 1/27=4 mg, Fri 1/28=0 mg, Sat 1/29=4 mg, Sun 1/30=4 mg, Mon 1/31=4 mg, Tues 2/2=4 mg, Wed 2/3=VA nurse will recheck do 4 mg..." On 03/01/22 at 4:30 p.m., LPN #3 was asked if they obtained clarification from the physician about Res #9's Coumadin order written on 01/20/22 for a missing dose on 02/01/22. This nurse stated, "I did not notice 02/01/22 was missing from the order." 3. Res #22's diagnoses included atrial fibrillation, arthritis, and dementia without behavioral disturbance. A "Medication Self-Administration Safety Screen," dated 09/14/20, read in parts, "... resident may self-administer medications with supervision. Complete this assessment prior to resident initiating self-administration of medication and with any medication order changes, change in function/condition that might affect the resident's ability to safely self-administer medications. Ongoing assessment should occur at a minimum of quarterly. Use clinical judgment with section B to determine if or what level of self-administration will be allowed..." A "Physician's Order," dated 02/28/22, read in parts, "...Resident may keep specified medications at the bedside...PT/INR q weekly on Thursday...Allopurinol tablet 300 mg give one tablet by mouth once a day related to Gout, Probiotic give 70 mg by mouth one time a day for preventative unsupervised self-administration..." On 03/02/22 at 11:45 a.m., LPN/DON #8 was asked if Res #22 had an up-to-date assessment to self-administer medications; and stated it was	C1951		

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C1951	Continued From page 17 dated, "09/14/20." On 03/07/22 at 9:37 a.m., Res #22 provided a list of medication that did not include allopurinol or a probiotic. Res #22's list included AREDS (eye vitamins) in the morning and in the evening and atorvastatin in the evening. 4. Res #32's diagnoses included essential hypertension, acute on chronic diastolic (congestive) heart failure, and major depressive disorder. A "Medication Self-Administration Safety Screen," dated 09/29/20, read in parts, "... Annual assessment list all current medications and dosages..." A "Physician's Order," dated 02/28/22, read in parts, "...Resident may keep specified medications at the bedside...Fluoxetine 10 mg tablet give one tablet by mouth one time a day, Cozaar tablet 50 mg give one tablet my mouth two times a day, Protonix 40 mg tablet give one tablet by mouth one time a day...Metoprolol 25 mg extended release give one tablet by mouth one time a day..." On 03/07/22 at 9:37 a.m., Res #32 provided a list of medications; and stated they administered 1/2 tablet of metoprolol and 1/2 tablet of the losartan and 1/2 tablet of citalopram. These did not match the physician's orders. Res # 32 also reported and listed aspirin 81 mg, calcium 500 mg with D3, mini-omega 3, Co-Q10, atorvastatin 20 mg, and vitamin C 500 mg on the medication list. At 12:20 p.m., LPN/DON #8 was asked if Res #32 had an up-to-date assessment to self-administer medications; and stated it was	C1951		

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C1951	Continued From page 18 dated, "09/29/20." This nurse was asked if the physician's orders matched Res #32's medication list; and stated no. 5. Res #28's "Physician's Order, " dated 03/02/22, read in parts, "...Location: [room on memory care unit], diagnoses Alzheimer's disease, essential (primary) hypertension..." There was no physician's orders to indicate the Res was on the memory care unit. On 03/02/22 at 5:20 p.m., LPN/DON #8 was asked if Res #28 had a physician's order for admission to the memory care unit; and stated no. 6. Res #29's "Comprehensive Assessment," dated 09/10/21, documented he was admitted to the assisted living center on 06/16/21 with a diagnosis of hyperlipidemia. Res #29 was alert and oriented x 4 [person, place, time, and situation]. Res #29 was independent of eating, dressing, transferring, toileting, and ambulation with a one person assist with bathing. There was no physician's orders to indicate the resident was on the memory care unit. On 03/02/22 at 5:15 p.m., LPN/DON #8 was asked about resident #29 being on the secured unit; and stated there should have been a nurse's note. On 03/03/22 at 1:50 p.m., a child of resident #29 stated the resident had been found close to the front door on the first floor, but he was lost and didn't know the date it had happened. The clinical record did not include documentation of this incident.	C1951		

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NAME OF PROVIDER OR SUPPLIER QUAIL RIDGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120		
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C2123	Continued From page 19	C2123		
C2123 SS=F	310:663-21-2(b)(3) DEADLINES FOR FILING (b) The license application shall be filed in accordance with the following deadlines: (3) The application for renewal of the license of an existing continuum of care facility or assisted living center, with no transfer of ownership or operation, shall be filed by the renewal date specified on the existing license. Each initial license shall be effective for one hundred eighty (180) days from the issue date. The renewal license shall be issued for a period of twelve (12) months from the date of issue. Provided that licenses may be issued for a period of more than twelve (12) months, but not more than twenty-four (24) months, for the license period immediately following the effective date of this provision in order to permit an equitable distribution of license expiration dates to all months of the year. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to file for a license renewal in a timely manner. The interim Executive Director identified 148 residents who resided at the center. Findings: On 02/25/22 at 11:15 a.m., the center's expired license, dated 02/20/22, was observed hanging on the wall across from the receptionist desk. At 11:20 a.m., the interim Executive Director stated the license was not current and had expired on 02/20/22. The interim Executive	C2123		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF PROVIDER OR SUPPLIER QUAIL RIDGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C2123	Continued From page 20 Director stated they did not know if there had been an application made for a new license. On 03/02/22 at 1:41 p.m., the BOM stated the center started working on the license renewal on 02/28/22. The BOM was asked what the time frame was for renewing the center's license; and stated they had a 30 day grace period to renew once it expired.	C2123		

Delivery via email to: sarah.bagby@quailridgeassistedliving.com

April 5, 2022

License Number: AL5523

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

Survey Event ID: 9V2111

Dear Ms. Bagby:

On **March 8, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **Tag C921-**It was indicated corrective action would be completed on 05/30/22. The plan of correction date shall not exceed sixty (60) calendar days of receipt of notice of violation.
- **Tag C930-** It was indicated corrective action would be completed on 05/30/22. The plan of correction date shall not exceed sixty (60) calendar days of receipt of notice of violation.
- **Tag C1505-** It was indicated corrective action would be completed on 05/30/22. The plan of correction date shall not exceed sixty (60) calendar days of receipt of notice of violation.
- **Tag C1922-** It was indicated corrective action would be completed on 05/30/22. The plan of correction date shall not exceed sixty (60) calendar days of receipt of notice of violation.
- There is no indication of how often or how long audits will be conducted to ensure medications are administered as ordered by the physician.
- **Tag C1923-** It was indicated corrective action would be completed on 05/30/22. The plan of correction date shall not exceed sixty (60) calendar days of receipt of notice of violation.
- **Tag C1951-** It was indicated corrective action would be completed on 05/30/22. The plan of correction date shall not exceed sixty (60) calendar days of receipt of notice of violation.

- **Tag C2123-** It was indicated corrective action would be completed on 05/30/22. The plan of correction date shall not exceed sixty (60) calendar days of receipt of notice of violation.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Katie Stagner

Digitally signed by Katie
Stagner
Date: 2022.04.05 16:00:59
-05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/30/2022

Facility Name: Quail Ridge Senior Living

License Number: AL5523

Survey Event ID: 9V2111

Date Survey Completed: 3/8/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921

Based on: Based on record review and interview, the center failed to perform medication reviews by the RN or pharmacy consultant at least monthly.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn therefrom. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Scirah Bougluz, ED

Date 3/31/2022

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
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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/30/2022

Facility Name: Quail Ridge Senior Living

License Number: AL5523

Survey Event ID: 9V2111

Date Survey Completed: 3/8/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C930

Based on: Based on record review and interviews, the center failed to have a licensed administrator responsible for the operations of the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn therefrom. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature *Sarah Bagley, ED*
OAC 310:663-25-4(F)

Date 3/31/2022

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
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/30/2022

Facility Name: Quail Ridge Senior Living

License Number: AL5523

Survey Event ID: 9V2111

Date Survey Completed: 3/8/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: Based on observation, record review, and interview, the center failed to: a) follow physicians order for monitoring and management of glucose for one (#17) of three sampled residents reviewed for glucose monitoring; b) administer medications as ordered by the physician for one (#1) of five sampled residents reviewed for medication administration; and c) administer medications as ordered by the physician for three (#24, 30, and #31) of three sampled residents reviewed for timeliness of medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn therefrom. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The physician's orders for identified residents #17, 1, 24, 30, and #31 were reviewed with nursing staff to ensure glucose monitoring, medication administration and timeliness as ordered.

All residents with physician's orders have the potential to be affected.

All licensed nurses and medication aides will be in-serviced on glucose monitoring, medication administration, and timeliness as ordered.

Audits will be conducted by the administrator/designee to ensure glucose monitoring, medication administration, and timeliness as ordered. Audits will be conducted weekly x 1 month, then monthly x 2 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.

5/30/2022

Administrator's Signature

OAC 310:663-25-4(F)

Sarah Bagley, ED

Date 3/31/2022

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

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: [Surveyor](#)

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text.](#)

Facility in Compliance by: [Click here to enter a date.](#)