OKLAHOMA
State Department
of Health

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

May 27, 2022

License Number: AL5523

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

Survey Event ID: E3F611

Dear Ms. Bagby:

On **May 18, 2022,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action will be completed for each violation; and
(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: 2022.05.27 15:29:33 -05'00'

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

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Quail Ridge Senior Living**
Address: **12401 Trial Oaks Drive**
City, State, Zip: **Oklahoma City, OK 73120**
Provider #: **AL5523**
Complaint #: **OK00058807**
Investigation Date(s): **05/17/22 and 05/18/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure qualified staff members were available in an emergency.	S

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

An unannounced on-site investigation was initiated on Tuesday, May 17, 2022 at 11:15 a.m.

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

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

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

Thank you for bringing these concerns to our attention.

Ed Roth Preventative Medical Consultant

Date report completed: 05/23/2022

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 _____	05/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (OK00058807) was conducted on 05/17/22 and 05/22/22.	C 000		
C1505 SS=D	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		

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C1505	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure: ~ staff checked respiration and pulse prior to initiating cardiopulmonary resuscitation (CPR) and ~ the nurse was aware of the CPR being performed to provide that information to the Emergency Medical Services Authority (EMSA) as well as the physician for one (#1) of one sampled residents reviewed for unresponsivness and needing CPR. No other residents were identified as becoming unresponsive and requiring CPR since January 1, 2022. Findings: A "For Emergency Intervention" policy, dated???, read in parts, "... to ensure an emergency medical team (911) is called for any resident determined to be in a life threatening situation...if respiration cease prior to arrival of the EMT unit, and resident does not have a signed DNR, basic life support trained staff will begin basic life support as required...when resident had been transported the following information shall be entered into the residents file...time 911 called, time EMT arrived...time physician notified and by whom...when rescued breathing started, was complete CPR started...time resident was transported, by whom..."	C1505		

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C1505	Continued From page 2 A "Nurse's Note," dated 05/01/22 at 6:27 p.m., read in parts, "...change in condition, Resident was observed with LOC [loss of consciousness] in the dining room chair during dinner, this Nurse was called, and Resident was assisted to the floor, assessment was made pulse and respirations were noted, but Resident was unresponsive. This Nurse called 911 EMSA [emergency medical services Authority] here, Resident was transferred to ER [emergency room name deleted] for evaluation as indicated vital signs obtained were O2 SAT [oxygen saturation] 91% HR [heart rate] 62 and chest Rising was noted. Dr. on call was called and notified, family was called and this nurse was not able to get hold of any family member will try again." The nurse's note was signed by LPN #1. [Rashid Migezo]. There was no documentation in the nurse's notes Resident #1's physician, and EMSA had been notified that cardiopulmonary resuscitation (CPR) had been performed prior to the resident being sent to the emergency room On 05/17/22 at 2:55 p.m., Resident #3 stated the Activities Life Enrichment staff member conducted the CPR and they [Resident #3] counted for them. Resident #3 stated it took LPN #1 seven minutes before arriving in the dining room. On 05/17/22 at 3:51 p.m., the Activities Life Enrichment stated they worked on 05/01/22 and had performed CPR on Resident #1. The Activities Life Enrichment stated they had current CPR training. They stated they did not check for respiration and pulse, but while providing the breaths and compressions no air was coming out. The Activities Life Enrichment identified LPN #1 as the nurse who arrived at the scene and put	C1505		

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C1505	Continued From page 3	C1505		

oxygen on the resident then told the supervisor, the Resident Services Director CPR was intiated and what happened.

On 05/18/22 at 9:38 a.m., Resident #1 and #2 were interviewed about the incident in the dining room. Resident #1 stated they did not recall everything that happened. Resident #2 stated CPR was performed on Resident #1 and if they had not Resident #1 would have died. Resident #2 stated when Resident #1 was transferred to the hospital and came back they were not sure what caused the unresponsiveness.

On 05/18/22 at 10:26 a.m., Licensed Practical Nurse #1 stated Resident #1 was eating in the dining room with Resident #2 and lost consciousness and was laid down on the floor. Licensed Practical Nurse #1 stated he found the resident unresponsive but still breathing and was able to locate a pulse. He identified the Activities Life Enrichment, Resident #2 and Resident #3 as the individuals with Resident #1 when entering the dining room. The Licensed Practical Nurse then stated Resident #3 informed them that CPR had to be performed, but it was not necessary due to a pulse and respiration was found. The Licensed Practical Nurse stated he did not talk with anyone that was present to find out if CPR had been initiated, and stated that would have been important to find out and provide the information for the doctor and EMSA. Licensed Practical Nurse #1 also stated it took over five minutes to respond because it was a large facility and they were located in the North building when paged. Licensed Practical Nurse #1 then stated at the time time of the page from the front desk they were not with anyother resident.

On 05/18/22 at 11:04 a.m., the Resident Service

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C1505	Continued From page 4 Director stated they supervised the Activities Life Enrichment and was told about the CPR being initiated and was very upset even though they had been trained. The Resident Service Director then stated the only thing needing to be corrected was the pulse and respiration was not checked before CPR was initiated. On 5/18/22 at 11:15 a.m., Receptionist #1 stated CPR was started by the Activities Life Enrichment, had radioed to Licensed Practical Nurse #1 of the emergency in the dining room, and did not know how long it took for the Licensed Practical Nurse to get into the dining room. Receptionist #1 confirmed the Licensed Practical Nurse was located in the North building when radioed. On 05/18/22 at 12:55 p.m., the Activities Life Enrichment confirmed she was performing CPR when Licensed Practical Nurse #1 came into the dining room. On 05/18/22 at 1:24 p.m., the Executive Director stated 911 should be called immediately when a life threatening situation occurred and the nurse should respond right away unless another emergency was going on. The Exectuive Director than stated it should take less than five minutes for the nurse to come from the North building to the dining room. The Executive Director then stated CPR was performed by the activities Life Enrichment and the nurse assessed the resident when they arrived and determined CPR was not needed. The Executive Director than stated she was not aware the nurse did not know that CPR was performed on Resident #1 and that information should have been provided to the doctor and EMSA.	C1505		

OKLAHOMA
State Department
of Health

REPORT REVISED

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

June 29, 2022

License Number: AL5523

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

Survey Event ID: E3F611

Dear Ms. Bagby:

This letter replaces the notice sent on **May 27, 2022**. On **June 17, 2022,** representatives from the Oklahoma State Department of Health (OSDH) continued and concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

(5) Include dates when corrective action will be completed for each violation; and
(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

23 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: 2022.06.29 10:32:31 -05'00'

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

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Quail Ridge Senior Living**
Address: **12401 Trial Oaks Drive**
City, State, Zip: **Oklahoma City, OK 73120**
Provider #: **AL5523**
Complaint #: **OK00058807**
Investigation Date(s): **05/17/22, 05/18/22 and 06/17/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure qualified staff members were available in an emergency.	S

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

An unannounced on-site investigation was initiated on Tuesday, May 17, 2022 at 11:15 a.m.

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

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

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

Thank you for bringing these concerns to our attention.

Ed Roth Preventative Medical Consultant

Date report completed: 05/23/2022

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	AL5523	A. BUILDING: _____ B. WING _____	06/17/2022

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C 000	INITIAL COMMENTS A complaint investigation (OK00058807) was conducted on 05/17/22, 05/18/22 and 06/17/22. Listed below are abbreviations that will be used throughout this document. CPR- cardiopulmonary resuscitation DNR-do not resecitate EMT-emergecny medical technician EMSA- Emergency Medical Services Authority LOC- level of consciousness	C 000		
C1505 SS=D	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	C1505		

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C1505	Continued From page 1 of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff checked respiration and pulse prior to initiating cardiopulmonary resuscitation (CPR) for one (#1) of one sampled resident reviewed for unresponsiveness for whom CPR was performed. No other residents were identified as becoming unresponsive and requiring CPR since January 1, 2022. Findings: An undated facility policy titled, "For Emergency Intervention", read in parts, "... to ensure an emergency medical team (911) is called for any resident determined to be in a life threatening situation...if respiration cease prior to arrival of the EMT [emergency medical technician] unit, and resident does not have a signed DNR, basic life support trained staff will begin basic life support as required..." On 05/17/22 at 2:55 p.m., Resident #3 stated the	C1505		

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	AL5523	A. BUILDING: _____ B. WING _____	06/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 2 Activities Life Enrichment staff member conducted CPR on Resident #1. On 05/17/22 at 3:51 p.m., a staff member whose title was, Activities Life Enrichment, stated they worked on 05/01/22 and had performed CPR on Resident #1. The Activities Life Enrichment stated they had current CPR training. They stated they did not check for respiration and pulse, but knew it should have been checked. They further stated Resident #1's chest was not rising. Resident #1was unresponsive and needed assistance. The Activities Life Enrichment stated CPR was started round 5:00 p.m., right after happy hour. There was no documentation in the clinical record when CPR was started on Resident #1. On 05/18/22 at 9:38 a.m., Resident #1 and #2, husband and wife, were interviewed about the incident in the dining room on 05/01/22. Resident #1 stated they did not recall anything that happened, but was told CPR had been performed. Resident #2, who was present at the time of the incident on 05/01/22, stated CPR was performed on Resident #1. On 05/18/22 at 1:24 p.m., the Executive Director stated Resident #1 "fainted" and the Activities Life Enrichment went into the dining room and initiated CPR. The Executive Director then stated she had been told by the Activities Life Enrichment no pulse and respiration had been checked prior to initiating CPR.	C1505		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT	C1912		

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 _____	06/17/2022

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
C1912	Continued From page 3 (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement.	C1912		

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 _____	06/17/2022

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
C1912	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to report to the Oklahoma State Department of Health an incident when a resident received treatment after being transferred by Emergency Medical Services Authority (EMSA) for one of one incidents reviewed. Findings: An undated facility policy titled "Incident/Accident Reporting", read in parts, "All incidents/accidents must be reported in a timely fashion to...Executive Director and others as required....when reporting...notify proper authorities as required..." A nurses progress note dated 05/01/22 at 6:27 p.m.,for Resident #1 read in parts, "....change in condition, Resident was observed with LOC [level of consciousness] in the dining room chair during diner [sic]...Resident was assisted to the floor...Resident was unresponsive...called 911 EMSA here, Resident was transferred to ER[emergency room name deleted]...for evaluation as indicated..." A hospital record titled, "Emergency Medical Services Authority-West", dated 05/01/22, read in part, "...Pt [patient] was assessed...18g [gauge] iv [intravenous] was established...Pt was administered approximately 700 mls of NS [normal saline] via iv...was administered 1 mg [milligram] of Narcan in 0.5 mg increments via iv...Pt was carried to the cot...Pt transported to [hospital name deleted]..."	C1912		

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 _____	06/17/2022

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
C1912	Continued From page 5 There was no documentation to show the incident with treatment was reported to the Oklahoma State Department of Health. On 06/17/22 at 12:14 p.m., the Executive Director stated a Resident that received Narcan and fluids would be considered treatment and would be reportable. The Executive Director then stated there was an incident report in Resident #1's electronic medical record, but the health department was not notified.	C1912		

OKLAHOMA
State Department
of Health

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

July 13, 2022

License Number: AL5523

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

Survey Event ID: E3F611

Dear Ms. Bagby:

On **June 17, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 29, 2022**.

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

Respectfully,

Tempal Killman Digitally signed by Tempal Killman
Date: 2022.07.13 12:07:22 -05'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/4/2022** **Facility Name:** Quail Ridge Senior Living **License Number:** AL5523 **Survey Event ID:** E3F611 **Date Survey Completed: 6/17/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: record review and interview, the facility failed to ensure staff checked respiration and pulse prior to initiating cardiopulmonary resuscitation (CPR) for one (#1) of one sampled resident reviewed for unresponsiveness for whom CPR was performed.

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 their from. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #1 was properly assessed by licensed staff at the time of the incident and it was determined the resident was breathing but had a decreased LOC. The resident was sent to the hospital for an evaluation and returned the same day with no hospital treatment and no new orders.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents receive medical care and have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Staff has been in-serviced on job descriptions, performing within designated scope of practice, and accurate reporting of incidents to appropriate staff. Direct care staff has also been reeducated on CPR and emergency response.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	. Audits will be conducted be the administrator/designee to ensure appropriate response and implementation of care by direct care staff. Audits will by 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.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/29/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Sarah Bagby** OAC 310:663-25-4(F)	**Date 7/4/2022**

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 Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/4/2022** **Facility Name:** Quail Ridge Senior Living **License Number:** AL5523 **Survey Event ID:** E3F611 **Date Survey Completed: 6/17/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1912	Based on: record review and interview, the facility failed to report to the Oklahoma State Department of Health an incident when a resident received treatment after being transferred by Emergency Medical Services Authority (EMSA) for one of one incidents reviewed.

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 their from. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #1 was properly assessed by licensed staff at the time of the incident and it was determined the resident was breathing but had a decreased LOC. The resident was sent to the hospital for an evaluation and returned the same day with no hospital treatment and no new orders. Incidents with hospital treatment will be reported as required per regulation.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents receive medical care and have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Administrative staff has been re-educated on incident reporting and the regulatory requirements. Incidents involving actual treatment at the hospital, per regulation, will continue to be reported as required.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	. Audits will be conducted be the administrator/designee to ensure proper reporting of incidents as required by regulation. Audits will by 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.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/29/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Sarah Bagby OAC 310:663-25-4(F)			**Date 7/4/2022**
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 Department
of Health

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

October 3, 2022

License Number: AL5523

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

Survey Event ID: E3F612

Dear Ms. Bagby:

On **September 29, 2022,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 17, 2022,** have now been corrected effective **July 29, 2022.**

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

Sincerely,

Katie Stagner
Digitally signed by Katie Stagner
Date: 2022.10.03 08:40:48 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5523	A. BUILDING: _____ B. WING _____	R-C 09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS A revisit was conducted from 09/12/22 through 09/14/22, 09/28/22 and 09/29/22. All deficiencies from the 06/17/22 survey were cleared.	{C 000}		

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