OKLAHOMA
State Department
of Health

**Delivery via email to:** jennifer.gilmore@quailridgeassistedliving.com; james.walker@quailridgeassistedliving.com; sarah.martin@quailridgeassistedliving.com

January 4, 2024

License Number: AL5523

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

**Survey Event ID: IVPQ11**

Dear Ms. Martin:

On **December 14, 2023**, 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.

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. 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 Services**, then **click on Long Term Care**. 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Quail Ridge Senior Living**
**Address:** **12401 Trail Oaks Drive**
**City, State, Zip:** **Oklahoma City, OK 73120**
**Facility ID:** **AL5523**
**Complaint #:** **OK00061526**
**Investigation Date(s):** **December 11th – 15th, 2023**

## ALLEGATION

The center failed to provide bathing assistance according to contract.

An unannounced on-site investigation was initiated 12/11/2023 at 7:54 a.m.

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

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

**A Summary of Complaint Investigation:**

Resident service contracts were reviewed. Facility policy and procedures were reviewed. Grievances and resident council minutes were reviewed. Documentation of ADL services provided to residents was reviewed.

A tour of the facility was conducted upon entrance and at other times throughout the survey. Residents were observed neat, clean, and dressed appropriately. Staff were observed in resident apartments assisting with showers.

Staff, residents, and family members were interviewed.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 12/15/2023

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Quail Ridge Senior Living**
**Address:** **12401 Trail Oaks Drive**
**City, State, Zip:** **Oklahoma City, OK 73120**
**Facility ID:** **AL5523**
**Complaint #:** **OK00061795**
**Investigation Date(s):** **December 11th – 15th, 2023**

## ALLEGATION

The center failed to ensure hot water boilers were in working condition, showers were in good repair and plumbing was in good repair.

An unannounced on-site investigation was initiated 12/11/2023 at 7:54 a.m.

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

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

**A Summary of Complaint Investigation:**

Grievances and resident council minutes were reviewed. Maintenance logs and receipts for equipment and repairs were reviewed.

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Toilets, sinks, and showers were tested for proper functioning. Water temperatures were tested. Observations were made in resident apartments and common areas for signs of water damage.

Staff, residents, and family members were interviewed.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 12/15/2023

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Quail Ridge Senior Living**
**Address:** **12401 Trail Oaks Drive**
**City, State, Zip:** **Oklahoma City, OK 73120**
**Facility ID:** **AL5523**
**Complaint #:** **OK00061809**
**Investigation Date(s):** **December 11th – 15th, 2023**

## ALLEGATION

The center failed to have and/or implement an effective infection control program.

An unannounced on-site investigation was initiated 12/11/2023 at 7:54 a.m.

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

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

**A Summary of Complaint Investigation:**

Facility policy and procedures were reviewed. Grievances and resident council minutes were reviewed. Facility supply requisitions and receipts were reviewed.

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Housekeeping staff were observed cleaning and re-stocking bathrooms in resident apartments and common areas.

Staff, residents, and family members were interviewed.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 12/15/2023

OKLAHOMA
State Department
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# INVESTIGATIVE REPORT

**Facility:** **Quail Ridge Senior Living**
**Address:** **12401 Trail Oaks Drive**
**City, State, Zip:** **Oklahoma City, OK 73120**
**Facility ID:** **AL5523**
**Complaint #:** **OK00061941**
**Investigation Date(s):** **December 11th – 15th, 2023**

## ALLEGATIONS

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|---|
| The center failed to ensure residents smoked in designated areas for safety of all residents. |
| The center failed to ensure a safe, odor-free and homelike environment. |

An unannounced on-site investigation was initiated 12/11/2023 at 7:54 a.m.

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

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

**A Summary of Complaint Investigation:**

Facility policies and procedures were reviewed. Grievances and resident council minutes were reviewed. Housekeeping schedules for resident apartments and common areas were reviewed.

A tour of the facility was conducted upon entrance, at other various times throughout the survey. Housekeeping staff were observed cleaning resident apartments and common areas. Observations were made in residents' apartments and in common areas.

Staff, residents, and family members were interviewed.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 12/15/2023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5523 | A. BUILDING: _____ B. WING _____ | C 12/14/2023 |

| 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 |
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| C 000 | INITIAL COMMENTS<br><br>Complaint investigations (#OK00061526, OK00061795, OK000809, and #OK00061941) were conducted on 12/11/23 through 12/14/23.<br><br>Facility Census: 136<br><br>Listed below are abbreviations that will be used throughout this document.<br><br>admin - administrator<br>ED - Executive Director<br>DON - Director of Nursing<br>IJ - immediate jeopardy<br>ISP - Individualized Service Plan<br>med - medicine<br>NC - nasal cannula<br>O2 - oxygen<br>via - by way of | C 000 | | |
| C 372 SS=G | 310:663-3-6(b) MANAGEMENT OF RISK<br><br>(b) The assisted living center shall specify the cause for concern, discuss the concern with the resident and representative, if any, and attempt to negotiate a written agreement that minimizes risk and adverse consequences and offers alternatives while respecting resident preferences.<br><br>This Rule is not met as evidenced by:<br>On 12/12/23 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to address Resident #3 smoking in their room with oxygen in progress. | C 372 | | |

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| C 372 | Continued From page 1<br><br>Resident #3's clinical record documented the following:<br>On 06/18/23, Resident #3 was found smoking in his room with O2 in progress.<br>On 07/07/23, a burnt nasal cannula was found in Resident #3's room.<br>On 11/19/23, Resident #3 was found smoking in his room with O2 in progress.<br>Smoking was not addressed in Resident #3's Service Plan.<br><br>On 12/11/23 at 8:55 a.m., Resident #3 was observed in his room with O2 in progress via NC. Two full medium sized O2 tanks, an Inogen O2 concentrator, and a stand-alone O2 concentrator were present in Resident #3's room. A strong tobacco smell was noted in the room along with two plastic cups of water containing cigarette butts on the counter. A box of cigarettes and a lighter were observed in Resient #3's shirt pocket and ashes were noted on their pants.<br><br>Smoking in the presence of oxygen has the potential for serious adverse outcome to the resident and others. Oxygen can build up and concentrate around clothes and bedding causing them to become flammable, especially in areas that are not well ventilated.<br><br>If this was not corrected immediately the resident could start a fire and cause serious injury, serious harm, serious impairment, or death to self or others.<br><br>On 12/12/23 at 1:28 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.<br><br>On 12/12/23 at 2:46 p.m., the Community | C 372 | | |

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| C 372 | Continued From page 2<br>Director was notified of the IJ situation.<br><br>On 12/14/23 at 10:15 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented:<br>Immediate corrective actions have been taken as follows due to non-compliance with following previous attempts with educating resident on appropriate smoking areas:<br>1. Cigarettes and lighters have been removed from [Resident #3's] apartment on 12/12/2023 and placed on med cart to be kept with facility staff to be checked out by resident. Staff will monitor that resident goes to appropriate smoking area and removes oxygen before smoking. Monitoring will continue indefinitely for [resident]. A cigarette check out and monitoring form has been placed on the 1st floor south med cart for staff and a 2 hour smoking safety check form has been placed on the 2nd floor south med cart.<br>2. Resident was educated [they] cannot smoke in [their] room or have cigarettes or lighters in [their] room on 12/12/23 at 1130am. Resident was given a formal letter from admin at this time.<br>3. DON has completed smoking assessment on 12/12/23 and determined resident may smoke independently after [they] checks out cigarettes and lighter from staff and they monitor/assist [resident] to the appropriate smoking area and turn off and remove [their] oxygen. DON has completed smoking assessments on 12/12/23 on all smoking residents and will continue to re-assess quarterly. All new residents who smoke will have a smoking assessment done upon admission and quarterly.<br>4. Resident's family has been notified of corrective actions to be taken due to non-compliance on 12/12/23.<br>5. Resident and family have been educated on | C 372 | | |

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| C 372 | Continued From page 3<br>12/12/23 on potential for serious harm to self or others such as fire due to smoking near oxygen or smoking injury if corrective actions are not followed which may result in termination of residency according to service agreement due to potential of harm to self and others.<br>6. Other residents who smoke have been educated they cannot smoke anywhere other than the designated smoking area on 12/12/23.<br>7. On 12/12/23 at 10pm community implemented smoking safety checks every 2 hours to monitor for smoking in the room for [Resident #3] and will continue to monitor for the entirety of [their] stay at Quail Ridge.<br>8. Emergency In-Service was held on 12/12/23 and 12/13/23 with staff in-person and via phone for staff unavailable on campus on corrective actions of keeping [Resident #3's] cigarettes and lighters on med cart, monitoring resident to make sure [they] goes to appropriate smoking area and removes oxygen, no smoking in [their] room, and implementation of safety checks every 2 hours & to notify admin if not followed. Employees are expected to follow Smoking policy and implement the rules and procedures.<br>9. Any employee who observes non-compliance with the smoking policy is expected to report their observations to their direct supervisor who will report to the ED.<br>10. Community has updated smoking policy on 12/13/23 to include smoking assessments for new smoking residents upon admission and quarterly thereafter. Staff was educated on updated smoking policy on 12/13/23.<br>11. Other residents on oxygen therapy will be educated on the dangers of smoking near oxygen.<br><br>The immediacy was lifted, effective 12/14/23 at 12 p.m., when all components of the plan of | C 372 | | |

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| C 372 | Continued From page 4 | C 372 | | |

removal had been completed. The deficient practice remained as isolated with potential for harm to the resident.

Based on record review, observation, and interview, the facility failed to establish interventions to eliminate risks of harm to self or others for one (#3) of one sampled resident who was oxygen dependent and non-compliant with the facility's smoking policy.

The administrator identified 136 residents resided in the facility. There were six residents who smoked and two residents who smoked and were oxygen dependent.

Findings:

A "Smoking" policy, effective 11/10/23, read in part, "...Smoking is only allowed in designated areas..."

A "Quail Ridge Senior Living- Resident Handbook", undated, read in part, "...Smoking...Smoking is not permitted in the building. This includes apartments, common areas, patios, and bathrooms..."

Resident #3 had diagnoses that included COPD, oxygen dependent, bipolar disorder, and PTSD.

On 12/11/23 at 8:55 a.m., Resident #3 was observed in their apartment sitting in their wheelchair with O2 in progress via NC. Two full medium O2 tanks, an Inogen O2 concentrator, and a stand-alone O2 concentrator were present in Resident #3's room. A strong tobacco smell was noted in the room along with two plastic cups of water and cigarette butts on the counter. A box of cigarettes and a lighter were observed in

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| C 372 | Continued From page 5<br>Resident #3's shirt pocket and ashes were noted on his pants.<br><br>On 12/12/23 at 11:11 a.m., the Lead LPN Preceptor acknowledged that Resident #3 did smoke in their room and stated they had spoken to the resident and their family member about it several times. The Lead LPN Preceptor was asked what interventions had been put into place to address Res #3's smoking in their room with oxygen and prevent an adverse outcome. They stated they had taken cigarettes from the resident before, but the resident kept getting more.<br><br>There was no documentation in Resident #3's clinical record of interventions being put into place to eliminate Resident #3's risks of harm to self or others because of their non-compliance with the facility's smoking policy.<br><br>On 12/12/23 at 11:43 a.m., the Administrator was asked the facility policy on smoking. They stated residents were not allowed to smoke anywhere in the facility except in the designated smoking area, including on their balconies. The Administrator acknowledged awareness of Resident #3's non-compliance with the facility smoking policy and confirmed the staff had not documented nor followed through with interventions to eliminate Resident #3's risks of harm to self or others. | C 372 | | |
| C1505 SS=E | 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care<br><br>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 | C1505 | | |

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| C1505 | Continued From page 6<br><br>63 O.S. 1-1918.(B)(5)<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the center failed to ensure information on the Senior Living Assessment/ISP related to smoking was completed accurately and in its entirety for four (#1, 4, 6, and #7) of six sampled residents who smoked cigarettes. | C1505 | | |

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| C1505 | Continued From page 7<br><br>The Administrator identified six residents in the facility who smoked cigarettes.<br><br>Findings:<br><br>1. Resident #1 had diagnoses that included type 2 diabetes and major depressive disorder.<br><br>A "Senior Living Assessment/ISP" for Resident #2, dated 07/29/23, was not completed for item #18.6 that asked if resident currently used tobacco.<br><br>On 12/11/23 at 10:32 a.m., Resident #2 acknowledged they have smoked cigarettes since before they were admitted to the facility and continues to smoke to this day.<br><br>2. Resident #4 had diagnoses that included dementia and malignant neoplasm of the testes.<br><br>"Senior Living Assessment/ISP's" for Resident #4, dated 08/09/23 and 09/06/23, were marked NO for item #18.6 that asked if resident currently used tobacco.<br><br>On 12/11/23 at 1:25 p.m., Resident #4's family member acknowledged they have smoked cigars since before they were admitted to the facility and continues to smoke to this day.<br><br>3. Resident #6 had diagnoses that included atherosclerotic heart disease and malignant neoplasm of breast.<br><br>"Senior Living Assessment/ISP's" for Resident #6, dated 03/10/21, 02/02/23, and 08/02/23 were marked NO for item #18.6 that asked if resident currently used tobacco. | C1505 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5523 | A. BUILDING: _____ B. WING _____ | C 12/14/2023 |

| 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 8<br><br>On 12/13/23 at 10:00 a.m., Resident #6 acknowledged they have smoked cigarettes since before they were admitted to the facility and continues to smoke to this day.<br><br>4. Resident #7 had diagnoses that included osteoarthritis and left kidney failure.<br><br>A "Senior Living Assessment/ISP" for Resident #7, dated 10/24/23, was not completed for item #18.6 that asked if resident currently used tobacco.<br><br>On 12/13/23 at 12:27 p.m., Resident #7 acknowledged they have smoked cigarettes since before they were admitted to the facility and continues to smoke to this day.<br><br>On 12/12/13 11:43 a.m., the Administrator reviewed the Senior Living Assessment/ISP's for Resident #1 and #7 and agreed item 18.6 was incomplete. The resident reviewed the Senior Living Assessment/ISP's for Resident #4 and Resident #6 and agreed item 18.6 had been completed incorrectly. | C1505 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** sarah.martin@quailridgeassistedliving.com

January 29, 2024

License Number: AL5523

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

**Survey Event ID: IVPQ11**

Dear Ms. Martin

On **December 14, 2023,** 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 **February 16, 2024**.

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

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 1/11/2024**<br>**Facility Name:** Quail Ridge Senior Living<br>**License Number:** AL5523<br>**Survey Event ID:** IVPQ11<br>**Date Survey Completed: 12/15/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 372 | Based on: record review, observation, and interview, the facility failed to establish interventions to eliminate risks of harm to self or others for one (#3) of one sampled resident who was oxygen dependent and non-compliant with the facility's smoking policy. |

**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? | Cigarettes and lighters have been removed from [Resident #3's] apartment on 12/12/2023 and placed on med cart to be kept with facility staff to be checked out by resident. Staff will monitor that resident goes to appropriate smoking area and removes oxygen before smoking. Monitoring will continue indefinitely for [resident]. A cigarette check out and monitoring form has been placed on the 1st floor south med cart for staff and a 2 hour smoking safety check form has been placed on the 2nd floor south med cart. Resident was educated [they] cannot smoke in [their] room or have cigarettes or lighters in [their] room on 12/12/23 at 1130am. Resident was given a formal letter from admin at this time. DON has completed smoking assessment on 12/12/23 and determined resident may smoke independently after [they] checks out cigarettes and lighter from staff and they monitor/assist [resident] to the appropriate smoking area and turn off and remove [their] oxygen. Resident and family have been educated on 12/12/23 on potential for serious harm to self or others such as fire due to smoking near oxygen or smoking injury if corrective actions are not followed which may result in termination of residency according to service agreement due to potential of harm to self and others. On 12/12/23 at 10pm community implemented smoking safety checks every 2 hours to monitor for smoking in the room for [Resident #3] and will continue to monitor for the entirety of [their] stay at Quail Ridge. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | The deficient practice remained as isolated with potential for harm to the resident (#3). |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

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|---|---|
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? | DON has completed smoking assessments on 12/12/23 on all smoking residents and will continue to re-assess quarterly. All new residents who smoke will have a smoking assessment done upon admission and quarterly. Other residents who smoke have been educated they cannot smoke anywhere other than the designated smoking area on 12/12/23. Emergency In-Service was held on 12/12/23 and 12/13/23 with staff in-person and via phone for staff unavailable on campus on corrective actions of keeping [Resident #3's] cigarettes and lighters on med cart, monitoring resident to make sure [they] goes to appropriate smoking area and removes oxygen, no smoking in [their] room, and implementation of safety checks every 2 hours & to notify admin if not followed. Employees are expected to follow Smoking policy and implement the rules and procedures. Any employee who observes non-compliance with the smoking policy is expected to report their observations to their direct supervisor who will report to the ED. Community has updated smoking policy on 12/13/23 to include smoking assessments for new smoking residents upon admission and quarterly thereafter. Staff was educated on updated smoking policy on 12/13/23. Other residents on oxygen therapy have been educated on the dangers of smoking near oxygen. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>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 above mentioned corrective actions. Audits will by conducted weekly x 3 months.<br><br>Progress and findings will be monitored by the QA committee to ensure continued effectiveness.<br><br>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? | 2/16/2024 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | |
|---|---|
| **Administrator's Signature** Sarah Bagby Martin<br>OAC 310:663-25-4(F) | **Date 1/11/2024** |

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<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 1/11/2024**<br>**Facility Name:** Quail Ridge Senior Living<br>**License Number:** AL5523<br>**Survey Event ID:** IVPQ11<br>**Date Survey Completed: 12/15/2023** |

**SUMMARY OF DEFICIENCY CITED BY OSDH**

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|---|---|
| ID Prefix Tag: C 1505 | Based on: record review and interview, the center failed to ensure information on the Senior Living Assessment/ISP related to smoking was completed accurately and in its entirety for four (#1, 4, 6, and #7) of six sampled residents who smoked cigarettes. |

**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? | Senior Living Assessment/ISPs for resident #2, #4, #6, & #7 were updated as required. |
| 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 require assessments/ISPs, therefore all residents have the potential to be affected. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? | Nursing staff was in-serviced on assessmnets/ISPs including completing them accurately and in their entirety. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>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 above mentioned corrective actions. Audits will by conducted weekly x 3 months.<br><br>Progress and findings will be monitored by the QA committee to ensure continued effectiveness.<br><br>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? | 2/16/2024 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | |
|---|---|
| **Administrator's Signature** **Sarah Martin, Executive Director**<br>OAC 310:663-25-4(F) | **Date 1/11/2024** |

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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| --- |
| If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.<br>Facility in Compliance by: Click here to enter a date. |