OKLAHOMA
State Department
of Health

Delivery via email to: sarah.bagby@quailridgeassistedliving.com; james.walker@quailridgeassistedliving.com

January 30, 2023

License Number: AL5523

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

Survey Event ID: X16V11

Dear Ms. Bagby:

On **January 26, 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 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

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5523**
Complaint #: **OK00059779**
Investigation Date(s): **01/25/23 and 01/26/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure the family council was treated with dignity and respect.	**US**

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

An unannounced on-site investigation was initiated on 01/25/2023 at 9:15 a.m.

A sample of three 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 family council was conducted.

The administrator provided a space for families and their invited guests to attend.

No staff made any negative comment about family council, at the time of the survey.

Family stated they appreciated the administrator and their accommodations to them,, at the time of the survey.

At the time of the survey, there was no deficient practice related to family council.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

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

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 01/26/2023

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5523**
Complaint #: **OK00059969**
Investigation Date(s): **01/25/23 and 01/26/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident.	S

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

An unannounced on-site investigation was initiated on 01/25/2023 at 9:15 a.m.

A sample of three 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 C1505 for details.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 01/26/2023

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Quail Ridge Senior Living**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5523**
Complaint #: **OK00060045**
Investigation Date(s): **01/25/23 and 01/26/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were not neglected.	**US**
2. The center failed to ensure equipment was in good repair and not a danger to residents.	**US**
3. The center failed to ensure residents received medication as ordered by the physician.	**US**

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

An unannounced on-site investigation was initiated on 01/25/2023 at 9:15 a.m.

A sample of three 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 environment, work orders, resident records, and hospital records was conducted.

Work orders, resident records and hospital records were reviewed.

There were no odors, no wet carpet, no residue, no mold and/or mildew, no leaking window in resident rooms observed throughout the survey.

At the time of the survey, no resident's complained about mold and/or mildew, windows, carpet, HVAC, or heat and air units.

Staff stated residents were able to call, go to the front desk, or the bistro to submit work orders for building maintenance.

At the time of the survey, there was no deficient practice related to neglect.

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

An investigation specific to electrical/outlets/breakers and water leaks around windows was conducted.

Work orders were reviewed.

There was no mold or mildew observed in resident rooms throughout the survey.

At the time of the survey, no resident complained about electrical outlets or breakers, wet carpet, or water leaks around windows.

Staff stated building maintenance provided resolutions to work orders.

At the time of the survey, there was no deficient practice related to equipment or equipment being a danger to residents.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to physician orders and medication administration records was conducted

Physician orders and MAR were reviewed.

No resident complained about not receiving their physician ordered medications, at the time of the survey.

Staff stated the resident received their physician ordered medications.

At the time of the survey, there was no deficient practice related to the resident receiving medication as ordered by the physician.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1-#3. 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.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 01/26/2023

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 _____	01/26/2023

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
C 000	INITIAL COMMENTS Complaint investigations (#OK00059779, OK00059969, and #OK00060045) were conducted 01/25/23 and 01/26/23. Listed below are abbreviations that will be used throughout this document. DON-director of nursing MAR-medication administration record mg-milligrams	C 000		
C1505 SS=G	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		

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 _____	01/26/2023

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 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to provide physician ordered medication in a timely manner for one (#2) of three sampled residents who required assistance with medication ordering and administration.

Findings:

The facility's "Medication Administration" policy, dated August 2006, read in part, "...To accurately prepare, administer and document all medication administration..."

The facility's "Residents Rights and Responsibilities Acknowledgement" policy, dated August 2006, read in part, "...Every resident shall have the right to receive adequate and appropriate medical care consistent with the established and recognized medical practice standards within the community..."

Resident #2 admitted to the center 07/19/11 with diagnosis to include bipolar disorder and depression.

Resident #2 was alert, oriented x4 (person, place, time, situation) and had good judgement.

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 _____	01/26/2023

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 2 A Physicians order, dated 12/01/22, read in part,"....Divalproex Sodium (Depakote) Tablet Delayed Release 125 MG...Give one tablet by mouth in the evening related to bipolar disorder..." On 01/25/23 at 3:56 p.m., resident #2 was interviewed about their Depakote not being administered 13 times in the month of December, they stated, "Not having my medications for those days I had more anxiety." On 01/26/23 at 10:00 a.m., LPN #1 stated medications should have been ordered seven days prior to the resident's medication needing a re-fill or before it ran out. On 01/26/23 at 10:11a.m., during record review of resident #2's December MAR and progress notes, the DON was asked about the records which documented resident(#2's) Depakote was not administered for thirteen days, they stated, " The Depakote, yes, the nurses should have ordered it three to seven days before they ran out." The DON stated staff documented the Depakote was not available to administer thirteen times in the month of December.	C1505		

OKLAHOMA
State Department
of Health

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

February 23, 2023

License Number: AL5523

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

Survey Event ID: X16V11

Dear Ms. Martin:

On **January 26, 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 **March 24, 2023**.

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: 2023.02.23 12:09:33 -06'00'

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/9/2023** **Facility Name:** Quail Ridge Senior Living **License Number:** AL5523 **Survey Event ID:** X16V11 **Date Survey Completed: 1/27/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Based on record review and interview, the facility failed to provide physician ordered medication in a timely manner for one (#2) of three sampled residents who required assistance with medication ordering and 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 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?	The physician's orders for identified resident #2 were reviewed with nursing staff to ensure medication administration and timeliness as ordered.
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 with physician's orders have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All licensed nurses and medication aides will be in-serviced on medication administration, and timeliness as ordered.
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 medication administration, and timeliness as ordered. 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. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/24/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Sarah Martin, Executive Director** OAC 310:663-25-4(F)	**Date 2/9/2023**

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: james.walker@quailridgeassistedliving.com; sarah.martin@quailridgeassistedliving.com

May 30, 2023

License Number: AL5523

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

Survey Event ID: X16V12

Dear Ms. Martin:

On **May 23, 2023,** 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 **January 26, 2023,** have now been corrected effective **March 24, 2023.**

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

Sincerely,

Katie Stagner

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 05/23/2023

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
{C 000}	INITIAL COMMENTS A revisit was conducted 05/23/23. All deficiencies from the 01/26/23 survey were cleared.	{C 000}		

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