

Delivery via email to: executivedirector@gardensatquailsprings.com

March 15, 2024

License Number: AL5514

Ms. Sarah Martin, Administrator
The Gardens at Quail Springs Assisted And Memory
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: 2R3C11

Dear Ms. Martin:

On **March 1, 2024**, 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 represented 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 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 a 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,

Tempal Killman

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

Enclosure

INVESTIGATIVE REPORT

Facility: The Gardens at Quail Springs Assisted Living and Memory Care
Address: 14300 North Portland
City, State, Zip: Oklahoma City, OK, 73134
Provider #: AL5514
Complaint #: OK00062325
Investigation Date(s): 02/27/24 through 03/01/24

ALLEGATION(S)

The center failed to ensure assistance with toileting was provided in a timely manner and according to the plan of care.
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The center failed to ensure adequate staff to meet the needs of the residents.
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The center failed to ensure adequate hydration was provided in a timely manner.

The center failed to ensure a quiet, comfortable and homelike environment.
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An unannounced on-site investigation was initiated 02/27/2024 at 10:43 a.m.

A sample of 15 residents, including any identified residents, 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 Summary of Complaint Investigation:

A tour of the facility was completed upon entrance and at other various times throughout the survey. Resident halls were observed for toileting assistance, transfer assistance, adequate staff, fluids available, and quiet, comfortable, homelike environment. Staff were observed assisting residents with incontinent care, toileting, transfers, dressing, brushing hair, and fluids.

Resident records were reviewed including assessments, resident contracts, plan of care, provider notes, medication administration, and physician orders. Facility policy and procedures were reviewed. Grievances were reviewed. Maintenance records were reviewed. Staffing records were reviewed. Employee files were reviewed.

Residents were interviewed related to the provision of toileting assistance, transfer assistance, adequate staff, hydration, and quiet, comfortable, homelike environment.

Staff members were interviewed regarding the policy for toileting assistance, transfers, staffing, hydration, and providing a quiet, comfortable, homelike environment.

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: 03/04/2024

INVESTIGATIVE REPORT

Facility: The Gardens at Quail Springs Assisted Living and Memory Care
Address: 14300 North Portland
City, State, Zip: Oklahoma City, OK, 73134
Provider #: AL5514
Complaint #: OK00062866
Investigation Date(s): 02/27/24 through 03/01/24

ALLEGATION(S)

The center failed to prevent the development of new/worsened pressure wounds and failed to ensure care and treatment was received to prevent constipation.
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The center failed to ensure assistance with incontinent care and repositioning was received in a timely manner and according to the contract, the standard of care and or the plan of care.

The center failed to ensure qualified staff provided care and treatment for residents with a colostomy.

An unannounced on-site investigation was initiated 02/27/2024 at 10:43 a.m.

A sample of 15 residents, including any identified residents, 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 Summary of Complaint Investigation:

A tour of the facility was completed upon entrance and at other various times throughout the survey. Resident halls were observed for interventions for pressure wounds, incontinent care, repositioning, and qualified staff. Staff were observed providing incontinent care and repositioning assistance.

Resident records were reviewed including assessments, resident contracts, plan of care, provider notes, medication administration, treatment notes, and physician orders. Facility policy and procedures were reviewed. In-services were reviewed. Grievances were reviewed. Staffing records were reviewed. Employee files were reviewed.

Residents were interviewed regarding the provision of incontinent care, repositioning, pressure wounds, constipation, and qualified staff.

Staff members were interviewed related to the policy on pressure wounds, constipation, incontinent care, repositioning, and qualified staff.

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: 03/04/2024

INVESTIGATIVE REPORT

Facility: The Gardens at Quail Springs Assisted Living and Memory Care
Address: 14300 North Portland
City, State, Zip: Oklahoma City, OK, 73134
Provider #: AL5514
Complaint #: OK00063096
Investigation Date(s): 02/27/24 through 03/01/24

ALLEGATION(S)

The center failed to ensure medications were administered according to the physician's orders.
The center failed to ensure the resident's representatives were notified when residents refused medication.
The center failed to ensure assistance with bathing, changing clothes, and housekeeping was provided according to the plan of care and/or contract.
The center failed to ensure discharge rights were honored according to the contract.

An unannounced on-site investigation was initiated 02/27/2024 at 10:43 a.m.

A sample of 15 residents, including any identified residents, 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls were observed for assistance with bathing, changing clothing, and housekeeping services. Staff were observed providing assistance with activities of daily living.

Resident records were reviewed including assessments, resident contracts, plan of care, provider notes, medication administration, discharge records, and physician orders. Facility policy and procedures were reviewed. Grievances were reviewed.

Residents were interviewed regarding the provision of medication administration, representative notification, assistance with bathing, changing clothes, housekeeping, and discharge rights.

Staff members were interviewed regarding the policy for medication administration, notification of changes, assistance with activities of daily living, housekeeping, and discharge rights.

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: 03/04/2024

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/01/2024
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT QUAIL SPRINGS ASSISTED AND N		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134		
(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 (#OK00062325, OK00062866, and OK00063096) were conducted on 02/27/24 and 03/01/24. Facility Census: 68 The following abbreviations will be used throughout this document. CNA- certified nurse aide CMA- certified medication aide LPN- licensed practical nurse RN- registered nurse	C 000		
C 371 SS=D	310:663-3-6(a) MANAGEMENT OF RISK (a) If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the resident and the resident's representative of such risk or consequences. This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to advise the resident and the resident's representative of the risks associated with the use of a seat belt in a wheelchair for one (#3) of six sampled residents reviewed for risk management. The Administrator identified a census of 68. Findings:	C 371		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/01/2024
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C 371	Continued From page 1 An "Administrative" policy, undated, read in part, "...Executing Shared Risk Agreements...When there are identified risks...these risks will be discussed with the resident and responsible person ...A plan will be developed to help reduce the risk...If it becomes evident that the resident does not choose to comply with the suggested actions, the residence will enter into a shared risk agreement with the resident and responsible party..." Resident #3 had diagnoses which included hypertension and atherosclerotic heart disease. Resident #3's individual service plan, dated 12/06/23, documented the resident required one person physical assistance to transfer in and out of electric scooter. Resident #3's clinical record did not contain a shared risk agreement. On 02/27/24 at 12:40 p.m., Resident #3 was observed seated in their electric wheelchair with a seat belt latched across their lap. The resident stated they could release the belt themselves, and it was used to keep them from falling over. On 02/28/24 at 11:30 a.m., the Administrator reported Resident #3 did not have a shared risk agreement. They stated they were new to the facility and would get a copy of the policy.	C 371		
C 544 SS=E	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be	C 544		

Oklahoma State Department of Health

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C 544	Continued From page 2 available upon request to the following: (1) the resident; (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure assessments were maintained for five years for two (#14 and #15) of eight sampled residents reviewed for assessments. The Administrator identified a census of 68. Findings: 1. Resident #14 admitted to the center on 08/31/22. There was no comprehensive assessment located in the resident's clinical record. 2. Resident #15 admitted to the center on 11/29/23. There was no comprehensive assessment located in the resident's clinical record. On 03/01/24 at 11:50 a.m., the Administrator stated they were having trouble finding the admission assessments for Resident #14 and #15. They stated they were not at the facility when they admitted. On 03/01/24 at 12:25 p.m., the Administrator stated they were unable to locate the admission assessments.	C 544		

Oklahoma State Department of Health

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C 961	Continued From page 3	C 961		
C 961 SS=E	310:663-9-6(a) MINIMUM STAFF FOR SERVICES (a) The right number of trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the continuum of care facility's, or assisted living center's, written emergency and disaster preparedness plan for fires and other natural disasters. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure qualified staff for colostomy care was provided for two (#3 and #4) of two sampled residents reviewed for colostomy care. The Administrator identified two residents with colostomies resided in the center.	C 961 C 961		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/01/2024
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C 961	Continued From page 4 Findings: An "In-Service Training Summary", dated 02/02/24, documented training on colostomy care was provided to 10 staff members which included CNAs and CMAs. It documented information on removing colostomy bags, cleaning stoma sites, emptying colostomy bags, and replacing colostomy bags. 1. Resident #3 had diagnoses which included diverticulitis of large intestines with perforation and abscess without bleeding. An "Individual Service Plan", dated 12/06/23, documented Resident #3 had a colostomy bag and required one person assist to burp and empty the bag. It documented a nurse was required one time a week to change the colostomy bag. On 02/27/24 at 12:40 p.m., Resident #3 stated one of the aides who had been trained to change the colostomy bag changed it weekly. 2. Resident #4 had diagnoses which included chronic pain and major depressive disorder. An "Individual Service Plan", dated 02/09/24, documented Resident #4 had a colostomy and urinary catheter. On 02/27/24 at 11:45 a.m. Resident #4 stated they had an issue with their colostomy bag bursting the other night. They stated a female staff member came in but stated, "Oh I don't do this." Resident #4 stated eventually a male came in and changed it, but stated it wasn't his job. Resident #4 stated there was no reason there wasn't a staff member on every shift trained to	C 961		

Oklahoma State Department of Health

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C 961	Continued From page 5 provide colostomy care. On 02/29/24 at 9:30 a.m., CMA #2 stated they changed colostomy bags and received a training class at the facility. They stated at their prior job the nurses changed the colostomy bag. They stated they did not receive any colostomy training during their training to become a CMA. On 02/29/24 at 9:36 a.m., CMA #1 stated they completed colostomy care along with CNAs. They stated they thought it was supposed to be a nurses' job. They stated they had not completed any training at the facility for colostomy care. On 02/29/24 at 9:40 a.m., CMA #3 stated the facility was having CNAs and CMAs empty and change colostomy bags. They stated there was not a schedule of when they were to be changed. They stated they were not trained on colostomy care when they went to school to become a CMA. They stated the facility did have a training where they showed them how to provide the care and gave them an opportunity to ask questions. On 02/29/24 at 10:00 a.m., CNA #1 stated they had changed the bag for Resident #4 before. They stated usually they just emptied the bags. They stated they believed LPNs were qualified to do colostomy care. They stated they had not received training on colostomy care at the facility. On 02/29/24 at 10:40 a.m., the Administrator stated when the home health agency came in on 02/02/24 and completed the colostomy training for staff, they did not complete a skills check off for the staff. The Administrator stated after further review, they were only supposed to train staff on emptying the bags not changing them. They stated the home health agency was to	C 961		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE GARDENS AT QUAIL SPRINGS ASSISTED AND N

14300 NORTH PORTLAND
OKLAHOMA CITY, OK 73134

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/01/2024
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C1304	Continued From page 7 needed..." Resident #5 had diagnoses which included history of falling, osteoarthritis, and chronic pain. An "Individual Service Plan", dated 01/12/24, documented staff were to assist Resident #5 with washing their hair, back, and lower trunk. A "Quarterly Assessment", dated 01/12/24, documented staff were to provide full assistance for bathing three times a week for Resident #5. On 02/29/24 at 2:30 p.m., Resident #5 stated they were hardly getting a bath at all. They stated they received bathing assistance eight days ago. They stated their understanding was they were supposed to be getting bathed three times a week. On 03/01/24 at 11:43 a.m., CNA #1 stated there was a shower book at the desk to follow. They stated it identified who was scheduled to get a bath/shower each day. They stated staff documented on paper and in the electronic record. They stated Resident #5 was to be bathed on the 3:00 p.m. to 11:00 p.m. shift Monday, Wednesday, and Friday. On 03/01/24 at 12:15 p.m., the Administrator stated staff were to follow the care plan for bathing residents. They stated staff should document electronically and on paper when a bath/shower was provided. They stated they were unable to locate the bathing records for Resident #5.	C1304		
C1321 SS=E	310:663-13-2(1) CONTENTS OF CONTRACT	C1321		

Oklahoma State Department of Health

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C1321	Continued From page 8 Each resident service contract shall contain a clear statement of the following: (1) assisted living center's name and address; This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure resident contracts had the facility's name for two (#1 and #6) of eight sampled residents reviewed for contracts. The Administrator identified a census of 68. Findings: Resident #1's contract, dated 09/13/21, documented "Villagio of Oklahoma City" as the assisted living facility. Resident #6's contract, dated 02/15/22, documented "Villagio of Oklahoma City" as the assisted living facility. On 02/28/24 at 9:00 a.m., the Administrator stated the facility was honoring the contracts they had with Villagio of Oklahoma City for one year. They stated the year was up in April. They stated the new group was going to review and revise contracts, but had not implemented it yet.	C1321		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 9 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the center failed to: a. provide care in a manner which prevented cross contamination for 10 (#1, 2, 3, 5, 7, 8, 9,	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/01/2024
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT QUAIL SPRINGS ASSISTED AND N		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134		
(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 10 10, 11, and 12); and b. utilize a safe technique when transferring a resident for two (#5 and #9) of 11 sampled residents observed for personal care. The Administrator identified a census of 68. Findings: An "Infection Control Policy", undated, read in part, "...Gloves are available to be used whenever there is a possibility of coming in contact with body fluids or blood..." On 02/28/24 at 5:14 a.m., CNA #3 and CMA #6 entered Resident #10's room, donned gloves, and CNA #3 removed the resident's wet pad and disposable. CNA #3 provided incontinent care using the same wipe several times. CNA #3 obtained another wipe and wiped several times with the same wipe then threw it away. CMA #6 told CNA #3 to use the wipe only once. Resident #10 was then placed on a bed pan. On 02/28/24 at 5:21 a.m., wearing the same gloves used in incontinent care, CNA #3 obtained new brief, socks, and pants. CNA #3 provided additional incontinent care with the same gloves. On 02/28/24 at 5:32 a.m., CNA #3 placed compression hose on the resident's legs, socks and pants on the resident with the same gloves. On 02/28/24 at 5:33 a.m., CNA #3 assisted the resident with transferring to their wheelchair, rubbed the resident's back, placed a bra on the resident wearing the same gloves. CNA #3 removed the old sheets, placed a new sheet and pad on the bed, and placed blankets on the bed with the same gloves, then removed the gloves.	C1505		

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C1505	Continued From page 11 On 02/28/24 at 5:45 a.m., CNA #3 removed the trash and placed it in the mechanical room. On 02/28/24 at 5:46 a.m., without washing or sanitizing their hands, CNA #3 entered Resident #5's room. CNA #3 donned gloves, drove the resident's electric scooter over to their room, removed the resident's disposable and used one wipe to wipe the front, left and center of the resident's peri area. The resident was turned to their side, CNA #3 provided additional incontinent care and attached a new brief. CNA #3 with the same gloves on, touched the bed controller. On 02/28/24 at 5:53 a.m., CMA #6 and CNA #3 were observed manually picking Resident #5 up from their bed and hoisted them onto their electric scooter. CNA #3 lifted the resident from behind holding underneath their arms while CMA #6 held the resident's legs. The resident did not participate in the transfer. On 02/28/24 at 5:57 a.m., CNA #3 and CMA #6 manually lifted Resident #5 again to scoot them back on their electric scooter. CNA #3 wearing the same gloves removed the trash and placed a new bag in the can. On 02/28/24 at 6:00 a.m., CNA #3 placed a clean blue long sleeve cover up on the resident, and brushed the resident's hair with the same gloves on. CNA #3 then removed their gloves and placed the trash bag in the mechanical room. On 02/28/24 at 6:05 a.m., without washing or sanitizing their hands, CNA #3 walked into Resident #7 and #8's room and donned gloves. CNA #3 provided incontinent care to Resident #7, removed the urine saturated brief, and sat it on	C1505		

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C1505	Continued From page 12 the floor next to the bed. CNA #3 pulled new brief up on Resident #7, pulled their pants up, and placed blankets back over them with the same gloves on. On 02/28/24 at 6:10 a.m., CNA #3 picked up the soiled brief off the floor, placed it in the trash, and removed and replaced their gloves. CNA #3 then moved over to Resident #8, removed brief, and provided incontinent care which included bowel. CNA #3 removed gloves, donned a new pair, placed new brief on resident, pulled their pants up, and removed the trash from the trash can. CMA #6 took the trash out of the room and CNA #3 removed their gloves. On 02/28/24 at 6:18 a.m., without washing or sanitizing their hands, CNA #3 entered Resident #3's room. CNA #3 donned a pair of gloves, checked the resident for incontinence, removed their gloves and exited the room. On 02/28/24 at 6:21 a.m., with the used gloves still in their hand, CNA #3 entered Resident #9's room. CNA #3 rubbed the resident with their free hand, then threw the used gloves away and donned a pair of gloves. On 02/28/24 at 6:22 a.m., CNA #3 obtained new clothes for the resident, removed blankets from the resident, performed incontinent care, and placed the wet brief on the resident's floor. On 02/28/24 at 6:25 a.m., with the same gloved hands, CNA #3 placed a new brief and black pants on the resident, and put maroon shoes on the resident's feet. Then the CNA picked up the soiled brief off the floor and placed it in the trash. CNA #3 moved the wheelchair beside the resident's bed and locked the wheels, then pulled	C1505		

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C1505	Continued From page 13 Resident #9's feet over the side of the bed. Resident #9 was moved to a seated position on the bed. CNA #3 held underneath Resident #9's arms standing in front of them and lifted the resident up, the resident pivoted and sat in the wheelchair. A gait belt was observed in a bucket on a chair in the resident's room. The CNA did not use the gait belt for the transfer. On 02/28/24 at 6:30 a.m., CNA #3 removed their gloves, brushed the resident's hair, opened the blinds, picked up the trash bag, and wheeled the resident out to the common area. CNA #3 took the trash to the mechanical closet. On 02/28/24 at 6:35 a.m., CNA #3 entered Resident #11's room and donned gloves without washing or sanitizing their hands. CNA #3 provided incontinent care to the resident, placed new brief, clothing, socks, and adjusted linens with the same gloves. On 02/28/24 at 6:45 CNA #3 removed their gloves, gave Resident #11 a drink of water, and exited the room. On 02/28/24 at 6:46 a.m., without washing or sanitizing their hands, CNA #3 entered Resident #12's room, donned gloves, and checked the resident for incontinence. CNA #3 then gave the resident a drink, and adjusted the resident's bed, linens, and pillows with the same gloves. The CNA removed their gloves, took the trash, and exited the room. On 02/28/24 at 6:52 a.m., CNA #3 threw the trash away in the mechanical room, donned gloves, and entered Resident #1's room with CMA #6. On 02/28/24 a 6:54 a.m., CMA #6 assisted the	C1505		

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C1505	Continued From page 14 resident to the bathroom. CAN #3 assisted the resident with washing their hands and face after using the bathroom. On 02/28/24 at 7:10 a.m., CNA #3 and CNA #1 entered Resident #2's room to provide incontinent care and transfer the resident using a lift. CNA #3 did not wash or sanitize their hands before providing care to the resident. On 02/28/24 at 7:25 a.m., CNA #3 stated staff should use a gait belt for transfers to ensure safety of residents. They stated they had worked at the facility for a week and had physically picked up Resident #5 since starting. They stated incontinent care was to be provided every two hours. They stated staff should wipe from front to back. They stated they should get a new wipe each swipe. CNA #3 stated soiled items were to be placed in a plastic bag and thrown away. They stated they should wash their hands after every resident and sanitize. On 02/28/24 at 10:33 a.m., the Administrator stated they could not locate a policy on transfers. They stated staff were to follow their plan of care whether it be one person or two person assist. RN #1 stated for a two person assist, staff should use the mechanical lift, if non weight bearing. The administrator stated staff could do arm under arm on each side if weight bearing. RN #1 stated staff should use a gait belt for transfers. The Administrator stated the center did have gait belts and physical therapy would determine if one was needed. On 02/28/24 at 10:35 a.m., RN #1 stated staff should wash/sanitize their hands when going from one resident to the next. They stated when hands were visibly soiled, staff should	C1505		

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C1505	Continued From page 15 wash/sanitize. They stated before and after donning gloves, staff should wash their hands. They stated staff were not to place soiled items on the floor. On 02/28/24 at 10:40 a.m., RN #1 stated for incontinent care, staff were to wash their hands, provide incontinent care, remove gloves, wash hands, then handle clean items. They stated staff should wipe front to back from cleanest to dirtiest.	C1505		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to ensure a resident	C1923		

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C1923	Continued From page 16 who was observed with bedside medications had an order to self-administer medications for one (#13) of one sampled resident observed with bedside medications. The Administrator identified five residents who self-administered medications resided at the center. Findings: A "Resident Controlled Medications" policy, undated, read in part, " ...The community will ensure that all medications will be stored in manner that prevents each resident from giving access to another resident's medications. The community will allow a resident who can independently self-administer medications to responsibly secure their own medications ...If the community assists a resident with the administration of one or more medications and the resident also self-administers the same or other medications, a written order shall specify that such self-administration is authorized ..." Resident #13 had diagnoses which included adrenal nodule, prostate cancer stage four, secondary cancer of bone, and secondary liver cancer. Resident #13's physician orders did not contain an order to self-administer medications. On 02/28/24 at 4:55 a.m., CNA #3 and CMA #6 entered Resident #13's room where the resident reported they would get their own medications. The resident reached over and pulled out a bottle of Oxycodone from their bedside table. On 02/28/24 at 5:05 p.m., CMA #4 and #5	C1923		

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C1923	Continued From page 17 entered the room and stated they were unaware Resident #13 had pain medications in their room. CMA #5 asked the resident who brought the medications to the center. The resident stated hospice. The resident stated the "powers that be" knew they had medications in their room including the administration. Resident #13 stated, "We've been leaving it here four months." CMA #6 and CMA #5 explained to the resident they could not have the medications in their room. On 02/28/24 at 5:10 a.m., the following medications were observed being removed from Resident #13's room by CMA #5: a. one 4.3 oz container of Aspercreme; b. two bottles of 100 mg docusate sodium; c. two bottles of docusate sodium with sennosides; d. one bottle of Trazadone 50mg; e. one bottle of Oxycodone 10 mg/acetaminophen 325mg; f. one bottle of duloxetine delayed release 30mg; g. one roll on container of Aspercreme; h. one bottle of Centrum silver men's vitamins; i. one bottle of acetaminophen 250mg/aspirin 250mg/ caffeine 65 mg; j. one Aspercreme spray can; k. one bottle of refresh tears; l. one bottle of Systane eye drops; and m. one container of afrin nasal spray. On 02/28/24 at 10:45 a.m., RN #1 stated they had not assessed Resident #13 for bedside medications. The Administrator stated they did not believe the resident did their own medications. The Administrator stated staff administered their medications. RN #1 stated Resident #13 was confused and would not be appropriate for bedside medications.	C1923		

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C5015 SS=E	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident;	C5015		

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C5015	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the center failed to ensure a plan of accommodation was developed for a resident who met discharge criteria for two (#2 and #5) of eight sampled residents reviewed for plan of accommodation. The Administrator identified a census of 68. Findings: An "Administrative" policy, undated, read in part, "...Residency Requirements ...The prospective resident ...must be able to participate in transfers with assistance ..." An "Administrative" policy, undated, read in part, "...Termination of Residency Due to Level of Care Change ...documented evidence will exist that supports the increasing care needs of the resident. These increasing care needs may result from physical deterioration, decline in mental ability or behavior problems ..." 1. Resident #2 had diagnoses which included chronic atrial fibrillation, essential hypertension, and osteoarthritis of the knee. A "Personal Service Plan", dated 01/19/24, documented Resident #2 required a mechanical lift with two care staff for transfers in and out bed	C5015		

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C5015	Continued From page 20 and recliner. An "Annual Resident Assessment" dated 01/24/24, documented Resident #2 required a mechanical lift with two person assistance. It documented the resident was not weight bearing. There was no plan of accommodation in the resident's clinical record. On 02/28/24 at 7:10 a.m., CNA #1 and #3 were observed transferring Resident #2 from their bed to the recliner using a mechanical lift. The resident did not participate in the transfer. 2. Resident #5 had diagnoses which included osteoarthritis, collapsed vertebrae, and polyneuropathy. An "Individual Service Plan", dated 01/12/24, documented Resident #5 required a two person assist. A "Quarterly Assessment", dated 01/12/24, documented Resident #5 required maximum assistance with getting on and off of a motorized scooter. There was no plan of accommodation in the resident's clinical record. On 02/28/24 at 5:53 a.m., CMA #6 and CNA #3 were observed manually picking Resident #5 up from their bed and hoisted them onto their electric scooter. CNA #3 lifted the resident from behind holding underneath their arms while CMA #6 held the resident's legs. The resident did not participate in the transfer. On 02/28/24 at 11:30 a.m., the Administrator	C5015		

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C5015	Continued From page 21 stated a plan of accommodation was for a resident who met discharge criteria, but were going to be allowed to remain in place. The plan of accommodation would be in place to say how the facility was going to meet the resident's needs. On 02/29/24 at 12:43 p.m., the Administrator stated they would use the admission criteria if changes occurred to determine whether a plan of accommodation or discharge was necessary.	C5015		



Delivery via email to: executivedirector@gardensatquailsprings.com

April 4, 2024

License Number: AL5514

Ms. Sarah Martin, Administrator
The Gardens At Quail Springs Assisted And Memory
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: 2R3C11

Dear Ms. Martin:

On **March 1, 2024**, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **April 26, 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
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/27/2024

Facility Name: The Gardens at Quail Springs

License Number: AL5514

Survey Event ID: 2R3C11

Date Survey Completed: 3/1/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C371

Based on: observation, record review and interview, the center failed to advise the resident and the resident's representative of the risks associated with the use of a seat belt in a wheelchair for one (#3) of six sampled residents reviewed for risk management.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The identified resident, Resident #3 will be evaluated by Licensed Therapy to evaluate need for seatbelt for resident; update care plan with MD and IDT involvement and add Risk Management Agreement per regulation by 4/15/2024.

All residents with electric scooters with seat belts have been audited; service plans were updated and risk management agreements will be in place by 4/15/2024.

The Executive Director and Wellness Director were inserviced and will implement service plans and risk agreements during ODH required assessment periods, within 14 days, annually, and promptly after a significant change related to seat belt use for residents using electric scooters.

Audits will be conducted by the administrator/designee to ensure residents with seat belts have risk agreements. Audits will be conducted weekly for one month, then monthly for two 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.

Records of Quality Assurance will be kept in the Executive Director's office.

4/15/2024

Administrator's Signature Sarah Martin, ED OAC 310:663-25-4(F)		Date 3/28/2024	
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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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: 3/27/2024	
	Facility Name: The Gardens at Quail Springs	
	License Number: AL5514	
	Survey Event ID: 2R3C11	
Date Survey Completed: 3/1/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C544	Based on: record review and interview, the center failed to ensure assessments were maintained for five years for two (#14 and #15) of eight sampled residents reviewed for assessments.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn therefrom. The POC is intended to constitute the facility's written allegation of continued compliance.		
REQUIRED ELEMENTS OF A PLAN		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?		Admission assessments for residents #14 and #15 were unable to be located. New assessments for identified residents will be conducted by 4/15/2024 and per ODH regulations.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Residents records will be audited to review the presence of admission assessments. Upon discovery of missing comprehensive assessments, identified residents will be conducted by 4/15/2024 and per ODH regulations.
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 managers in-serviced on requirement for keeping comprehensive assessments for the required amount of time (five years).
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 by the administrator/designee to ensure the presence of comprehensive assessments. Audits will be conducted weekly for one month, then monthly for two 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. The binder will be kept in the Executive Director's office.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		3/28/2024
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Sarah Martin, ED OAC 310:663-25-4(F)		Date 3/28/2024
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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: 3/27/2024

Facility Name: The Gardens at Quail Springs

License Number: AL5514

Survey Event ID: 2R3C11

Date Survey Completed: 3/1/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C961

Based on: record review and interview, the center failed to ensure qualified staff for colostomy care was provided for two (#3 and #4) of two sampled residents reviewed for colostomy care.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Residents #3 and #4 will have coordination by a licensed home health company to evaluate colostomy bag procedures/Health Maintenance Activities related to Colostomy Bag, stoma care and changes by 4/15/2024. Staff training will be individualized based on evaluations by 4/25/2024.

An audit of all residents will be conducted for presence of colostomy bag; licensed home health will evaluate procedures and staff training will be conducted based on the evaluations.

Interventions will be added to the service plans, and staff will be in-serviced on requirements for colostomy care by 4/15/2024.

Audits will be conducted by the administrator/designee to ensure medication administration, and timeliness as ordered. Audits will be conducted weekly for one month, then monthly for two 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.

The binder will be kept in the ED's office.

4/25/2024

Administrator's Signature Sarah Martin, ED

Date 3/28/2024

OAC 310:663-25-4(F)

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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: 3/27/2024	
	Facility Name: The Gardens at Quail Springs	
	License Number: AL5514	
	Survey Event ID: 2R3C11	
Date Survey Completed: 3/1/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1304	Based on: record review and interview, the center failed to ensure bathing assistance was provided per contract for one (#5) of three sampled residents reviewed for bathing assistance	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn therefrom. The POC is intended to constitute the facility's written allegation of continued compliance.		
REQUIRED ELEMENTS OF A PLAN		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 identified employee, CNA #1 received an inservice for service plans and for bathing/showers and record keeping. Resident #5's service plan was evaluated to ensure bathing was to be done three times per week.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Service plans related to bathing frequency will be audited and documentation for bathing assistance will be implemented for record keeping will be completed by 4/15/2024.
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 will receive inservice education for implementing tasks related to contracts and the service plans, along with documentation bathing assistance for record keeping purposes.
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 by the administrator/designee to ensure medication administration, and timeliness as ordered. Audits will be conducted weekly for one month, then monthly for two 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. The binder will be kept in the ED's office.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		4/15/2024
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Sarah Martin, ED		Date 3/28/2024
OAC 310:663-25-4(F)		

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