
Delivery via email to: carlisa@countrysideltc.com

September 10, 2025

License Number: AL1101

Ms. Carlisa Rogers, Administrator
Countryside Assisted Living Of Tahlequah
1380 N Heritage Lane
Tahlequah, OK 74464

Survey Event ID: BGV11

Dear Ms. Rogers:

On **August 27, 2025**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on 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: IDRCoordinator@health.ok.gov

or mail 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: Countryside AL
Address: 1380 N Heritage Ln.
City, State, Zip: Tahlequah, OK, 74464
Provider #: AL1101
Complaint #: OK00083156
Investigation Date(s): 08/26/25-08/27/25

ALLEGATION(S)
The center failed to have a nurse on staff to ensure the care and management of residents' needs.
The facility failed to have an administrator on staff to ensure the day-to-day operations of the facility.
enter text
enter text
enter text

An unannounced on-site investigation was initiated 08/26/2025 at 9:15 a.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(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: Entrance was made into the front of the building and greeted by the administrator. Residents were observed sitting at some tables in the lobby area and staff was interacting with some of the residents. The facility was clean and no foul odor detected upon entrance into the building and on the initial tour. Greeted by the administrator at the front desk and was introduced to the activity director, and the DON also during the initial tour.

The attached State form, Statement of Deficiencies, 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: 08/26/2025

INVESTIGATIVE REPORT

Facility: Countryside AL
Address: 1380 N Heritage Ln
City, State, Zip: Tahlequah, OK, 74464
Provider #: AL1101
Complaint #: OK00083937
Investigation Date(s): 08/26/25-08/27/25

ALLEGATION(S)
The facility failed to ensure care was provided according to the physician orders.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 08/26/2025 at 9:15 a.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(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: Entrance was made into the front of the building and greeted by the administrator. Residents were observed sitting at some tables in the lobby area and staff were interacting with some of the residents. The facility was clean, and no foul odor detected upon entrance into the building and on the initial tour. Review of policy and procedure for self-administration of medication and physician orders. Resident was not assessed for self medication.

The attached State form, Statement of Deficiencies, 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: 08/27/2025

INVESTIGATIVE REPORT

Facility: Countryside AL
Address: 1380 N Heritage Ln
City, State, Zip: Tahlequah, OK, 74464
Provider #: AL1101
Complaint #: OK00085139
Investigation Date(s): 08/26/25-08/27/25

ALLEGATION(S)
The facility failed to follow their policy and procedure to prevent a fall during a transportation.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 08/26/2025 at 9:15 a.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(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: Entrance was made into the front of the building and greeted by the administrator. Residents were observed sitting at some tables in the lobby area and staff was interacting with some of the residents. The facility was clean and no foul odor detected upon entrance into the building and on the initial tour. The van is currently in the shop being repaired and they are using public transportation.

The attached State form, Statement of Deficiencies, 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: 08/28/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464		
(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 (#OK00083156, OK00083937, and #OK00085139) were conducted on 08/26/25 through 08/27/25. Deficiencies were cited as a result of the survey. Facility Census 37 Listed below are abbreviations that will be used throughout this document. AD- activity director BM- business manager CHD - coronary heart disease CMA- certified medication aide DON- director of nursing ED- executive director FSBS- finger stick blood sugar GERD - gastro esophageal reflux disease LPN- license practical nurse Res- resident RN- registered nurse	C 000		
C 541 SS=D	310.663-5-4(a) CONDUCT OF ASSESSMENT (a) The assessments shall be completed by appropriate participation of health professionals trained in the assessment process. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a trained health professional completed an assessment for 1 (3) of three	C 541		

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: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464		
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C 541	Continued From page 1 sampled residents reviewed for assessments. The executive director identified 37 residents resided in the facility. Findings: Resident #3's preadmission assessment report, dated 05/09/25, showed the resident had diagnoses which included chronic kidney disease, autoimmune hemolytic anemia, chronic obstructive pulmonary disease, hypertension, and hemochromatosis. The "Resident Assessment Form," dated 05/09/25, did not contain a signature to indicate staff completion. On 08/27/25 at 10:21 a.m., the DON/LPN was asked if the assessment was completed by a trained staff. The DON stated they did not know who performed the assessment due to them not working at the facility at that time. On 08/27/25 at 11:55 a.m., the ED was shown the unsigned assessment for Res #3 which was completed on 05/09/25. The ED stated they did not know which nurse was employed here when the resident was admitted due to them not being employed at the facility at that time.	C 541		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician.	C 542		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464		
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C 542	Continued From page 2 This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure a Preadmission/14-day assessment was signed/coordinated by an RN or physician for 1 (#3) of 3 sampled residents reviewed for assessments. The ED identified 37 residents resided in the facility. Findings: A "Preadmission/14-day assessment," dated 05/09/25, showed Res#3 had diagnoses which included chronic kidney disease, autoimmune hemolytic anemia, chronic obstructive pulmonary disease, hypertension, and hemochromatosis. No signature was provided on the assessment. On 08/27/25 at 10:21 a.m., the DON/LPN was asked if the assessment was completed by a trained staff. The DON stated they did not know who performed the assessment due to them not working at the facility at that time. On 08/27/25 at 11:55 a.m., the ED was shown the unsigned assessment for Res #3 completed on 05/09/25. The ED stated they did not know which nurse was here when the resident was admitted.	C 542		
C1110 SS=D	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance	C1110		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464		
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C1110	Continued From page 3 committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a quality assurance committee met on a quarterly basis. The ED identified 37 residents resided in the facility. Findings: On 08/27/25 at 2:24 p.m., the ED was asked for the quality assurance committee meeting reports. The ED stated, "They have to look for the book." On 08/27/25 at 2:30 p.m. the book was reviewed and the last quality assurance meeting documented was held in the month of 04/2025. The ED stated, "They will make a checklist of the things that need to be corrected."	C1110		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464		
(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
C1911	Continued From page 4	C1911		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the center failed to submit a follow up report within 5 working days and failed to submit a final report within ten business days for 1 (#2) of 3 residents sampled for incident reports.	C1911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025
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C1911	Continued From page 5 The ED identified 37 residents resided in the facility. Findings: A facility policy titled "Incident Reporting," dated 06/03/24, read in part, "The investigation of the incident must be completed within 5 days from the event." Res #2's preadmission assessment, dated 09/07/24, showed the resident had diagnoses which included anxiety, GERD, CHD, anemia, hypertension, and depression. An "Incident Report Form," dated 07/24/25, read in part, "Driver turned left, and resident fell over in wheelchair on right side, and has a laceration on right side of scalp." On 08/26/25 at 2:10 p.m., The activity director was asked about the incident on 07/24/25. The activity director stated they did not secure the shoulder strap of Res #2, and when they turned the vehicle left, the resident fell on their right side causing the laceration to the right side of the scalp. The activity director stated Res #2 was admitted into the hospital on 07/24/25 for a subdural hematoma. The activity director stated they were immediately suspended from providing transportation for the next 30 days. The activity director stated they had to go through training and had to be signed off. A complete checklist when transporting residents would be double checked for 30 days by the business manager. On 08/26/25 at 1:35 p.m., Resident #2 stated they did not know why the employee did not	C1911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464		
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C1911	Continued From page 6 secure their shoulder strap. The department did not receive the follow up or final report. On 08/26/25 at 3:45 p.m. the ED was asked for the 5 day follow up report regarding the initial incident report on 07/24/25. On 08/26/25 at 4:00 p.m., The ED stated they did not think the final report was ever submitted. The ED was asked what the policy was for notifying the department of reportable incidents. They stated they were not sure, they just recently started this position.	C1911		
C1920 SS=D	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement their policy for self-administration medication assessment for 1 (#1) of 3 sampled residents reviewed for medication administration. The ED identified 37 residents resided in the facility. A facility policy titled "Medication Self Administration," dated 06/03/22, read in parts, "If a resident wishes to self-administer and the	C1920		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464		
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C1920	Continued From page 7 Resident's physician has determined that the Resident does not require assistance."..."The Administrator or Resident Care Director will complete the Assessment for Self-Administration of Medication form." The residents preadmission assessment, dated 03/10/25, showed Res #2 had diagnoses which included Type 2 diabetes mellitus with other specified complications and nonrheumatic aortic (valve) stenosis. A "Physician's Order", dated 07/08/25, read in part."[Resident #1] is allowed to self-inject insulin with supervision."..."a. Lantus Subcutaneous Solution Inject 10 units." On 08/26/25 at 10:09 a.m., Res #1 stated the CMA's observed them self inject their insulin nightly. On 08/27/25 at 11:55 a.m., the ED was asked if they could provide a copy of the assessment for self-medication for Res #1. The ED stated they would look on their desk in the stack of health papers left by the previous DON and administrator. The ED stated they couldn't find the self-medication assessment. On 08/27/25, at 4:00 p.m. the DON/LPN presented a "Self-Medication Administration Assessment" for Res #1 to self medicate their insulin with supervision.	C1920		

Delivery via email to: carlisa@countysideltc.com

November 17, 2025

License Number: AL1101

Ms. Carlisa Rogers, Administrator
Countryside Assisted Living Of Tahlequah
1380 N Heritage Lane
Tahlequah, OK 74464

Survey Event ID: BGV12

Dear Ms. Rogers:

On **November 10, 2025**, an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **August 27, 2025**, have now been corrected effective **October 27, 2025**.

If you have any questions concerning the information in this letter, please contact me 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/10/2025
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464		
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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 11/10/25. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Delivery via email to: carlisa@countrysideltc.com

September 30, 2025

License Number: AL1101

Ms. Carlisa Rogers, Administrator
Countryside Assisted Living Of Tahlequah
1380 N Heritage Lane
Tahlequah, OK 74464

Survey Event ID: BGV11

Dear Ms. Rogers:

On **August 27, 2025**, 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 in a timely manner. **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 **October 27, 2025**.

We will conduct a revisit 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

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(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 (#OK00083156, OK00083937, and #OK00085139) were conducted on 08/26/25 through 08/27/25. Deficiencies were cited as a result of the survey. Facility Census 37 Listed below are abbreviations that will be used throughout this document. AD- activity director BM- business manager CHD - coronary heart disease CMA- certified medication aide DON- director of nursing ED- executive director FSBS- finger stick blood sugar GERD - gastro esophageal reflux disease LPN- license practical nurse Res- resident RN- registered nurse	C 000		
C 541 SS=D	310:663-5-4(a) CONDUCT OF ASSESSMENT (a) The assessments shall be completed by appropriate participation of health professionals trained in the assessment process. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a trained health	C 541	Refer to POC Template, Survey event BGVT11, C541	

	professional completed an assessment for 1 (3) of three			
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Oklahoma State Department of Health
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE STATE FORM 6889 BGV11 If continuation sheet 1 of 8

PRINTED: 09/10/2025
 FORM APPROVED

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2025	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464				
(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 541	Continued From page 1 sampled residents reviewed for assessments. The executive director identified 37 residents resided in the facility. Findings: Resident #3's preadmission assessment report, dated 05/09/25, showed the resident had diagnoses which included chronic kidney disease, autoimmune hemolytic anemia, chronic obstructive pulmonary disease, hypertension, and hemochromatosis. The "Resident Assessment Form," dated 05/09/25, did not contain a signature to indicate staff completion. On 08/27/25 at 10:21 a.m., the DON/LPN was asked if the assessment was completed by a trained staff. The DON stated they did not know who performed the assessment due to them not working at the facility at that time. On 08/27/25 at 11:55 a.m., the ED was shown the unsigned assessment for Res #3 which was completed on 05/09/25. The ED stated they did not know which nurse was employed here when the resident was admitted due to them not being employed at the facility at that time.	C 541		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician.	C 542	Refer to POC template BGV11, C542	

Oklahoma State Department of Health

STATE FORM 6899 BGV11 If continuation sheet 2 of 8

PRINTED: 09/10/2025
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Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464	

(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 542	Continued From page 2 This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure a Preadmission/14-day assessment was signed/coordinated by an RN or physician for 1 (#3) of 3 sampled residents reviewed for assessments. The ED identified 37 residents resided in the facility. Findings: A "Preadmission/14-day assessment," dated 05/09/25, showed Res#3 had diagnoses which included chronic kidney disease, autoimmune hemolytic anemia, chronic obstructive pulmonary disease, hypertension, and hemochromatosis. No signature was provided on the assessment. On 08/27/25 at 10:21 a.m., the DON/LPN was asked if the assessment was completed by a trained staff. The DON stated they did not know who performed the assessment due to them not working at the facility at that time. On 08/27/25 at 11:55 a.m., the ED was shown the unsigned assessment for Res #3 completed on 05/09/25. The ED stated they did not know which nurse was here when the resident was admitted.	C 542		
C1110 SS=D	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance	C1110	Refer to POC template BGV11, C1110	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH 1380 N HERITAGE LANE TAHLEQUAH, OK 74464					
(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	
C1110	Continued From page 3 committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a quality assurance committee met on a quarterly basis. The ED identified 37 residents resided in the facility. Findings: On 08/27/25 at 2:24 p.m., the ED was asked for the quality assurance committee meeting reports. The ED stated, "They have to look for the book." On 08/27/25 at 2:30 p.m. the book was reviewed and the last quality assurance meeting documented was held in the month of 04/2025. The ED stated, "They will make a checklist of the things that need to be corrected."	C1110			

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Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH				
STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE TAHLEQUAH, OK 74464				
(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

C1911	Continued From page 5 The ED identified 37 residents resided in the facility. Findings: A facility policy titled "Incident Reporting," dated 06/03/24, read in part, "The investigation of the incident must be completed within 5 days from the event." Res #2's preadmission assessment, dated 09/07/24, showed the resident had diagnoses which included anxiety, GERD, CHD, anemia, hypertension, and depression. An "Incident Report Form," dated 07/24/25, read in part, "Driver turned left, and resident fell over in wheelchair on right side, and has a laceration on right side of scalp." On 08/26/25 at 2:10 p.m., The activity director was asked about the incident on 07/24/25. The activity director stated they did not secure the shoulder strap of Res #2, and when they turned the vehicle left, the resident fell on their right side causing the laceration to the right side of the scalp. The activity director stated Res #2 was admitted into the hospital on 07/24/25 for a subdural hematoma. The activity director stated they were immediately suspended from providing transportation for the next 30 days. The activity director stated they had to go through training and had to be signed off. A complete checklist when transporting residents would be double checked for 30 days by the business manager. On 08/26/25 at 1:35 p.m., Resident #2 stated they did not know why the employee did not	C1911		
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Oklahoma State Department of Health

STATE FORM 6899 BGV11 If continuation sheet 6 of 8

PRINTED: 09/10/2025
FORM APPROVED

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025
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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH		1380 N HERITAGE LANE TAHLEQUAH, OK 74464		
(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
C1911	Continued From page 6 secure their shoulder strap. The department did not receive the follow up or final report. On 08/26/25 at 3:45 p.m. the ED was asked for the 5 day follow up report regarding the initial incident report on 07/24/25. On 08/26/25 at 4:00 p.m., The ED stated they did not think the final report was ever submitted. The ED was asked what the policy was for notifying the department of reportable incidents. They stated they were not sure, they just recently started this position.	C1911		
C1920 SS=D	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement their policy for self-administration medication assessment for 1 (#1) of 3 sampled residents reviewed for medication administration. The ED identified 37 residents resided in the facility. A facility policy titled "Medication Self Administration," dated 06/03/22, read in parts, "If a resident wishes to self-administer and the	C1920	Refer to POC Template BGV11, C1920	

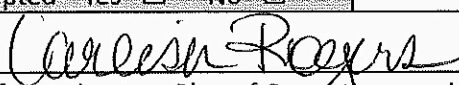
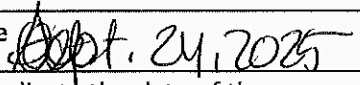
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 N HERITAGE LANE COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH TAHLEQUAH, OK 74464				
(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
C1920	Continued From page 7 Resident's physician has determined that the Resident does not require assistance."..."The Administrator or Resident Care Director will complete the Assessment for Self-Administration of Medication form." The residents preadmission assessment, dated 03/10/25, showed Res #2 had diagnoses which included Type 2 diabetes mellitus with other specified complications and nonrheumatic aortic (valve) stenosis. A "Physician's Order", dated 07/08/25, read in part."[Resident #1] is allowed to self-inject insulin with supervision."..."a. Lantus Subcutaneous Solution Inject 10 units." On 08/26/25 at 10:09 a.m., Res #1 stated the CMA's observed them self inject their insulin nightly. On 08/27/25 at 11:55 a.m., the ED was asked if they could provide a copy of the assessment for self-medication for Res #1. The ED stated they would look on their desk in the stack of health papers left by the previous DON and administrator. The ED stated they couldn't find the self-medication assessment. On 08/27/25, at 4:00 p.m. the DON/LPN presented a "Self-Medication Administration Assessment" for Res #1 to self medicate their insulin with supervision.	C1920		

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 9-19-25		
	Facility Name: Countryside Assisted Living of Tahlequah.		
	License Number: AL-1101		
	Survey Event ID: BGVT11		
Date Survey Completed: Aug 27, 2025			
SUMMARY OF DEFICIENCY CITED BY OSDH Conduct of assessment			
ID Prefix Tag: C541	Based on: the facility failed to ensure a trained health professional completed an assessment for 1 of 3 sampled residents reviewed for assessments		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS	
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		Resident #3's assessment was reviewed and signed by an RN 9-11-25	
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 current resident assessments were audited and signed by an RN 9-11-25.	
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?		Pre-admission assessments will be completed by the DON and signed by an RN at least monthly. The ED, DON, or designee will review assessments weekly for 8 weeks, then monthly to ensure continued compliance with this rule.	
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.		Each month the ED, DON, or designee will make sure all pre-admission assessments have been signed monthly in perpetuity. The log will be kept in the ED office in a binder for reference.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		October 27, 2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F)		Date Enter a date of signature Sept 24, 2025	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE			
	Current Date: 9/19/25			
	Facility Name: Countryside Assisted Living of Tahlequah			
	License Number: 1101-AL			
	Survey Event ID: BGV11.			
Date Survey Completed: Aug 27, 2025				
SUMMARY OF DEFICIENCY CITED BY OSDH				
ID Prefix Tag: C542		Based on: the facility failed to ensure a preadmission/14 day assessment was signed/coordinated by an RN or physician for 1 (#3) of 3 sampled residents reviewed for assessments.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION				
Assisted Living Center's Comments: NA				
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 assessment for resident #3 was reviewed and signed by the RN 9-11-25		
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 other current resident pre-admission assessments were reviewed for signatures. All found to lack signatures were signed by RN 9-11-25.		
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?		New assessments will be reviewed weekly by the DON, ED or designee for 8 weeks and monthly thereafter. The assessments will be signed monthly by a Physician, physician's representative, or RN monthly.		
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.		After 8 weeks the ED, DON or designee will continue to maintain a log of all new admits and ensure all have been reviewed and signed by a Physician, Physician's representative, or RN.		
OSDH Response: Element accepted Yes ☐ No ☐				
5. On what date will corrective action be completed?		October 27, 2025		
OSDH Response: Element accepted Yes ☐ No ☐				
Administrator's Signature OAC 310:663-25-4(F)		<i>Caroisa Rogn</i>		Date <i>Sept 24, 2025</i>
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		Submitted by		
Items Below Are For OSDH Use Only				
Plan of Correction: ☐ Acceptable ☐ Unacceptable			Date: 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: 9-19-25		
	Facility Name: Countryside Assisted Living of Tahlequah		
	License Number: 1101-AL		
	Survey Event ID: BGV11		
			Date Survey Completed: 8-27-25
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C1110		Based on: based on record review and interview the facility failed to ensure a quality assurance committee met on a quarterly basis.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
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?		A make-up QAPI meeting was held 9-19-25. This meeting educated new employees/members of the QAPI committee on the purpose of QAPI and to address current QAPI issues. A regular quarterly meeting date was established for 10-5-25.	
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 will benefit from the QAPI committee being educated and establishing a quarterly meeting for performance improvement purposes.	
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?		QAPI meeting dates will be set for the next 6 months and reminders sent to staff.	
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.		QAPI meetings will be set and held every quarter and minutes will be kept in the ED office. Any logs associated with improvement programs will be kept in the ED office.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		October 27, 2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)			Date  Oct. 24, 2025
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		Submitted by	
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable		Date:	Surveyor:

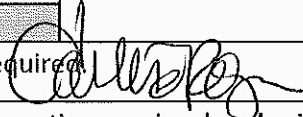
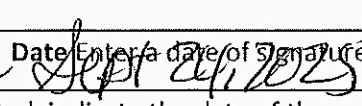
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: C1911		
	Facility Name: Countryside Assisted Living of Tahlequah		
	License Number: AL-1101		
	Survey Event ID: BGVT11		
Date Survey Completed: 8-27-25			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C1911	Based on: record review and interview the center failed to submit a follow up report within 5 working days and failed to submit a final report within 10 business days for 1 (#2) of 3 residents sampled for incident reports		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: NA			
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?		An follow up/final report was submitted for resident #2 9-19-25	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		An audit of incident reports was conducted for the 60 day period prior to the complaint investigation to determine if there were any failures to report. It was determined this follow up report was the only missing state reportable incident.	
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 staff was educated on incident reporting. For 8 weeks the ED and the DON will review incident reports 3X per week to ensure no failures in reporting occur.	
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.		After 8 weeks, the ED, DON or designee will continue to monitor all incident reports to ensure there is no failure to report or follow up reporting.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		October 27, 2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F)		Date Enter a date of signature <i>Sept 21, 2025</i>	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			

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

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

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

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 9-19-25	
	Facility Name: Countryside Assisted Living of Tahlequah	
	License Number: AL-1101	
	Survey Event ID: BGVT11	
		Date Survey Completed: 8-27-25
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1920	Based on: record review and interview the facility failed to implement their policy for self administration medication assessment for 1 (#1) of 3 sampled residents reviewed for medication administration	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: NA.		
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		Resident #1's self-administration assessment was completed and signed on _____
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		An audit was conducted of all residents to determine if any other residents were self administering medications. No other current residents were found to self administer medications.
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?		The DON will evaluate any residents who wish to self-administer medications in the future with the facility's self administration tool. The DON or designee will audit residents desiring to self administer medications for cognitive ability, understanding of medication regimen and safety awareness weekly for 8 weeks then every 6 months or upon significant change in condition.
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.		The ED, DON, or designee will audit new resident administration assessments weekly. After 8 weeks all residents self administering medication will be monitored every 6 months or upon change in condition to evaluate competency.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		October 27, 2025
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Administrator signature required 		Date Enter a date of Signature. 
OAC 310:663-25-4(F) 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.			