OKLAHOMA
State Department
of Health

Delivery via email to: lpn_583@yahoo.com

March 23, 2023

License Number: AL2502

Ms. Dana Vandever, Administrator
The Willows
301 Melville Drive
Pauls Valley, OK 73075

RE: Survey Event ID: R69S11

Dear Ms. Vandever:

On **March 8, 2023**, agents from our office concluded a State Licensure survey in conjunction with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on March 8, 2023.

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

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

(1) Address how corrective action will be accomplished for affected residents;

(2) Address how other residents with the potential to be affected will be identified;

(3) Address measures or systemic changes to ensure the deficiency will not recur;

(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

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

(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may

be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: The Willows
Address: 301 Melville Drive
City, State, Zip: Pauls Valley, OK 73075
Provider #: AL2502
Complaint #: OK00059536
Investigation Date(s): 03/07/23 and 03/08/23

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to have qualified staff present to meet the needs of the residents.	US

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

An unannounced on-site investigation was initiated on 03/07/2023 at 10:10 a.m.

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

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to qualified staff to meet the needs of the residents was conducted.

Sampled resident contracts, assessments, and care plans were reviewed. The center's policies were reviewed related to receiving orders for prescription and non-prescription (over-the-counter) medications and related equipment and supplies from the pharmacy provider of their choice. A sampled selection of staff employee files was selected and reviewed for current certifications/licensures to determine qualifications to provide care to the center's residents.

A tour was conducted upon entrance to the center. There were no offensive odors detected in the rooms and/or hallways of the center. Residents were observed in the halls and sitting areas throughout the center. Staff were observed interacting with residents, assisting residents with activities of daily living, and answering call lights.

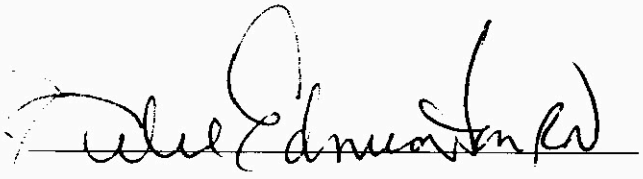
Sampled residents were interviewed and reported no concerns related to the staff's qualifications related to the delivery of care and services. Staff were interviewed related to qualifications related to taking orders from providers. Staff reported a lot of the providers faxed over physician's orders and they would notify the LPN or RN in charge of the fax for further instructions. The LPN reported the RN was in charge when she was on vacation and vice versa. The LPN reported the majority of providers in the community had their personal cell phone numbers. The LPN reported she had the cell phone numbers for most of the residents' physicians.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.



Julie Edmiaston RN, BSN

Date report completed: 03/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2502	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted on 03/07/23 through 03/08/23. A complaint investigation (#OK00059536) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: CNA- Certified Nurse Aide LPN- Licensed Practical Nurse ML- Milliliters Oz- Ounces PO- By mouth RN- Registered Nurse/Director of Nurses Tbsp- Tablespoon Tsp- Teaspoon	C 000		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2502	A. BUILDING: _____ B. WING _____	03/08/2023

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C1505	Continued From page 1 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, interview, and record review, the center failed to follow the physician orders for one (#8) of 9 residents reviewed for medications. The "Assisted Living Resident Condition and Care Overview," dated 03/07/23, identified 32 residents who resided in the facility. Findings: A "Residency Agreement/Service Contract," dated 08/01/14, for Resident #8, read in parts, " ...The Willows Assisted Living Residence will admit and care for people who require the ordering, storing, and administration of medication. The Willows Assisted Living Residence staff responsible for medication administration will be Medication Administration Technicians or Certified Medication Assistants ..."	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2502	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

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C1505	Continued From page 2 A hospice "Verbal Order," dated 02/23/23, read in parts, " ...Calcium Citrate with Magnesium and Vitamin D3 administer 1 tbsp orally daily; Give 1 tbsp to equal 15 ml read back and confirmed. Start Date 2/7/23. Metamucil 1 tsp powder; Administer 1 tsp orally daily; Mix 1 tsp Metamucil powder with 4 ounces water or juice-read back and confirmed. Start date: 02/07/23. The "MAR," dated March 2023, documented, " ...Liquid Calcium take one tablespoon one time daily ...Metamucil packet mix 1 teaspoon in 4 ounces of fluid (1/2 packet) one time daily ..." On 03/08/23 at 12:20 p.m., a medication pass was observed with CMA #1 and Resident #8. Calcium Magnesium Citrate with Vitamin D3 was pulled from the medication cart and 30 ml (cc's) was measured up in a plastic medicine cup. One package of Metamucil was pulled from the medication cart and mixed with 4 ounces of water and one multivitamin was prepared. CMA #1 delivered the medications to Resident #8 who was sitting at the dining room table eating lunch. On 03/08/23 at 12:45 p.m., CMA #1 was asked how many ml's were in a tablespoon. They stated 15 (ml) for a teaspoon and 30 (ml) for a tablespoon. They were asked to read the container for the Calcium Magnesium Citrate with Vitamin D3 container. They read 1 tablespoon (15 ml). They stated they gave the wrong dose. They were asked about the package of Metamucil they prepared for resident #8. They stated they poured the entire package in 4 oz of the water and it was the wrong dose. On 03/08/23 at 2:53 p.m., the Administrator was asked about the calcium for Resident #8. They stated the current dose should have been 1	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2502	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

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C1505	Continued From page 3 tablespoon and she stated she checked the Metamucil and 1/2 of the package contained 1 teaspoon and the CMA #1 should have only administered one half of the package.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: lpn_583@yahoo.com

April 11, 2023

License Number: AL2502

Ms. Dana Vandever, Administrator
The Willows
301 Melville Drive
Pauls Valley, OK 73075

Survey Event ID: R69S11

Dear Ms. Vandever:

On **March 8, 2023,** a relicensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 13, 2023**.

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

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2023.04.11 15:36:28 -05'00'

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

enc

PRINTED: 03/23/2023
FORM APPROVED

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2502	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

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C 000	INITIAL COMMENTS A relicensure survey was conducted on 03/07/23 through 03/08/23. A complaint investigation (#OK00059536) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: CNA- Certified Nurse Aide LPN- Licensed Practical Nurse ML- Milliliters Oz- Ounces PO- By mouth RN- Registered Nurse/Director of Nurses Tbsp- Tablespoon Tsp- Teaspoon	C 000		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment.	C1505		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Sandoval TITLE: Administrator (X6) DATE: 4/7/23

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/6/2023
Facility Name: The Willow Assisted Living Residence
License Number: AL2502
Survey Event ID: R69S11
Date Survey Completed: 3/8/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Based on observation, interview and record review, the center failed to follow the physician orders for one (#8) of 9 residents reviewed for medications.

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?	Immediately after the exit interview on 3/8/2023, CMA #1 was counseled on the importance of proper measuring of liquid and powdered medications. CMA #1 was also shown how to properly measure the ordered dose of each medication correctly by using the 5 ml line for the 1 teaspoon order of Metamucil before adding to the 4 ounces of liquid. CMA #1 was also shown how to properly administer 1 tablespoon of liquid calcium as ordered by pouring the liquid medication into a graduated plastic medication cup by first sitting the cup on a flat service and to pour the liquid calcium to the 15 ml line to = 1 tablespoon. All other staff members who are certified to administer medications have been educated on the proper administration of liquid and powdered medications. I have also placed a measurement guide in the front of the MAR binder for quick reference on the correct ml's to be given for such orders.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident who has a physician ordered medication that is in liquid or powdered form will be identified as a potential risk for incorrect measuring of such medications. Any resident who has such medications can be considered at possible risk for the improper dosing of that medication. In an effort to ensure that this does not happen, all physician orders containing liquid or powdered medications will be noted on the MAR to include the exact milliliters that must be administered to equal the ordered dose.
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 physician orders containing liquid or powdered medications will be noted on the MAR to include the exact milliliters that must be administered to equal the ordered dose. A measurement quide has been placed in the front of the MAR for quick reference on the milliliter to teaspoon and tablespoon conversion. This conversion will

	be added to the medication evaluation testing that we do on all of our certified medication administration staff each quarter.
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.	a) The Willows Assisted Living nursing staff will conduct an inservice for all CMA and MAT employees on the proper administration of liquid and powdered medication. Each CMA and MAT will also be tested individually to determine if liquid and powdered medications are being measured properly. b) This testing will be signed and dated by the nurse and employee and placed in the employee's file. These files will be audited and reviewed at each quarterly quality assurance meeting to ensure that this training and testing has been completed. c) Teaspoon and Tablespoon conversion training will be included for all current and future medication administration staff. Proof of testing and training will be signed and dated by both the nurse conducting the training and the employee. The signed test will then be placed in the employees file. This proof of testing and training will be audited at each quarterly quality assurance meeting and will be included in the minutes. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/13/2023
OSDH Response: Element accepted Yes ☒ No ☐	

Administrator's Signature **Dana D Vandever** OAC 310:663-25-4(F)	**Date 4/6/2023**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor

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

OKLAHOMA
State Department
of Health

Delivery via email to: lpn_583@yahoo.com

May 12, 2023

License Number: AL2502

Ms. Dana Vandever, Administrator
The Willows
301 Melville Drive
Pauls Valley, OK 73075

RE: Survey Event R69S12

Dear Ms. Vandever:

On **May 11, 2023,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 8, 2023,** have now been corrected effective **April 13, 2023.**

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2502	A. BUILDING: _____ B. WING _____	R 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/11/23. The center was in substantial compliance.	{C 000}		

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