
Delivery via email to: lpn_583@yahoo.com

April 26, 2024

License Number: AL2502

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

RE: Survey Event ID: OLIT11

Dear Ms. Vandever:

On **April 18, 2024**, agents from our office concluded a State Licensure survey 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 **April 18, 2024**.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (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 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 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 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER THE WILLOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 from 04/16/24 through 04/18/24. Facility Census: 37 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aide DM - diabetes mellitus DNR - do not resuscitate CKD - chronic kidney disease CPR - cardiopulmonary resuscitation GERD - gastroesophageal reflux disease HTN - hypertension LPN - licensed practical nurse QA - quality assurance Res - resident	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure proper food service sanitation requirements were followed. The "Assisted Living and Resident Care Overview" form, dated 04/16/24, documented 37 residents resided in the center. Findings:	C 391		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 391	Continued From page 1 On 04/16/24 at 9:18 a.m., a tour of the kitchen and dining room was conducted. The following observations were made. a. there was an accumulation of white and brown residue on the dish machine, b. the metal on the spray nozzle hose located on the three compartment sink was torn and the rubber was exposed, c. the gasket on the walk in cooler door was split and in bad repair, d. there was food spillage and brown residue on the floor in the walk in cooler, e. there was an accumulation of white residue on the black milk crates in the walk in cooler, f. unpasteurized shell eggs were stored on top of and next to shredded and sliced cheese in the walk in cooler, g. the gaskets on all three doors of the True cold prep cooler were split and in bad repair, h. there was black residue on the floor under the cooking equipment, reach in coolers, and dish washing area, i. there was an accumulation of grease on the cooking equipment, j. the lights were not shielded and/or shatterproof in the dry storage area, k. a cart with three bins of white dry products were not labeled in the dry storage area,	C 391		

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C 391	Continued From page 2 l. there was ice buildup in the reach in freezers in the dry storage area, m. there was an unlabeled spray bottle of a liquid in the drink station area, and n. there was a damp cloth stored on top of an unlabeled spray bottle in the drink station area. There were multiple gnats on the cloth and flying around the cloth. On 04/16/24 at 9:36 a.m., the dietary supervisor was asked how staff ensured food service areas were kept clean and maintained in good repair. They stated they cleaned daily. They stated maintenance concerns were reported to the administrator. They were asked about identification of products. They stated they should be labeled. They were asked how often pest control services were provided. They stated at least monthly. They were asked how staff prevented cross contamination with raw and ready to eat foods. They stated raw products should be stored on the bottom shelf. They stated the aides were responsible for maintaining the drink station in the dining room. They were made aware of the above observations.	C 391			
C 913 SS=E	310:663-9-1(3) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:	C 913			

Oklahoma State Department of Health

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C 913	Continued From page 3 (3) documenting the resident's living will or "Do Not Resuscitate Order." This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure accuracy of DNR orders for five (#4, 5, 6, 7, and #8) of eight sampled residents reviewed for code status. The "Assisted Living and Resident Care Overview" form, dated 04/16/24, documented 37 residents resided in the center. Findings: The center's "Do Not Resuscitate Orders" policy and procedure, dated 08/04/04, read in part, "...Acopy of the...DNR will be placed in the Resident's file..and also copies will be kept in the Resident's chart..." 1. Res #4 had diagnoses which included HTN, GERD, weight loss, and atrial fibrillation. The resident's hard chart was observed with an orange DNR sticker on the spine of the chart. An individualized plan of service, dated 02/21/24, documented the resident did not have a signed DNR form.	C 913		

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C 913	Continued From page 4 A "Resident Emergency Information" form, dated 02/23/24, documented the resident was a DNR. There was no signed DNR form on file with the center. On 04/17/24 at 1:27 p.m., the administrator/LPN was asked what was the protocol for determining a residents code status during an emergency. They stated there would be a DNR sticker on the residents' chart. They were asked to verify the resident's code status. On 04/17/24 at 1:38 p.m., the administrator/LPN stated the resident did not have a DNR on file with the center. 2. Res #5 had diagnoses which included HTN, acid reflux, insomnia, weight loss, and allergies. The resident's hard chart was observed with an orange DNR sticker on the cover and on the spine of the chart. An "Oklahoma DNR Consent" form, dated 11/06/19, documented the resident gave consent for a DNR. A "Resident Emergency Information" form, dated 06/09/21, documented the resident was a DNR. A "Resident Emergency Code" form, dated 06/11/21, documented if the resident should suffer what appeared to be either a cardiac or respiratory arrest to begin resuscitation with CPR after calling for emergency medical assistance. An individualized plan of service, dated 11/16/23, documented the resident was to be resuscitated.	C 913		

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C 913	Continued From page 5 On 04/18/24 at 10:16 a.m., the administrator/LPN was shown the orange DNR stickers on the resident's chart. They were shown the discrepancies in the documentation regarding the resident's code status. They stated the resident and/or their family would let the center know if they wished to revoke the DNR. 3. Res #6 had diagnoses which included HTN and CKD. The resident's hard chart was observed with an orange DNR sticker on the cover and spine of the chart. An individualized plan of service, dated 10/23/23, documented the resident did not have a signed DNR form. An undated "Resident Emergency Information" form, documented the resident was a DNR. There was no signed DNR form on file with the center. On 04/18/24 at 10:18 a.m., the administrator/LPN was shown the orange DNR stickers on the resident's chart. They were shown the discrepancies in the documentation regarding the resident's code status. 4. Res #7 had diagnoses which included CKD and DM. The resident's hard chart was observed with an orange DNR sticker on the spine of the chart. An individualized plan of service, dated 07/20/21, documented the resident was to be resuscitated.	C 913		

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C 913	Continued From page 6 A "Resident Emergency Information" form, dated 07/20/21, documented the resident was not a DNR. A "Resident Emergency Code" form, dated 07/20/21, documented if the resident should suffer what appeared to be either a cardiac or respiratory arrest no resuscitation should be attempted. An "Oklahoma DNR Consent" form, dated 12/13/21, documented the resident gave consent for a DNR. The DNR consent form was not signed in the presence of two witnesses. On 04/18/24 at 10:28 a.m., the administrator/LPN was asked what was the requirement for a DNR to be valid. They stated signatures and the date. They were shown the orange DNR sticker on the resident's chart and the discrepancies in the documentation regarding the resident's code status. 5. Res #8 had diagnoses which included paresis of lower extremities. The resident's hard chart was observed with an orange DNR sticker on the cover and spine of the chart An undated "Resident Emergency Code" form, documented if the resident should suffer what appeared to be either a cardiac or respiratory arrest no resuscitation should be attempted. An individualized plan of service, dated 12/14/22, documented the resident did not have a signed DNR form and was to be resuscitated. A "Resident Emergency Information" form, dated	C 913		

Oklahoma State Department of Health

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C 913	Continued From page 7 12/14/22, documented the resident was a DNR. There was no signed DNR form on file with the center. On 04/17/24 at 1:38 p.m., the administrator/LPN was shown the discrepancies in the documentation with the resident's code status. They were asked if the resident had a DNR on file at the center. On 04/17/24 at 1:55 p.m., the administrator/LPN stated the resident did not have a DNR form on file at the center.	C 913		
C 952 SS=E	310:663-9-5(b) STAFF QUALIFICATIONS (b) Each assisted living center shall ensure that staff members providing socialization, activity, and exercise services are qualified by training.	C 952		

Oklahoma State Department of Health

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C 952	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the designated activities staff member was qualified by training to provide activities. The "Assisted Living and Resident Care Overview" form, dated 04/16/24, documented 37 residents resided in the center. Findings: An undated staff roster identified the designated activities staff member was hired on 02/21/23. There was no documentation the designated activities staff member had received training to provide activities. On 04/17/24 at 2:37 p.m., the administrator/LPN was if the designated activities staff member had received training to provide activities. They stated they had not received training.	C 952		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance 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.	C1110		

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: AL2502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/18/2024
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C6000	Continued From page 10 (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this	C6000		

Oklahoma State Department of Health

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C6000	Continued From page 11 subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct registry screening and background checks for staff upon hire for three (CMA #1, CNA #1, and CNA #2) of five sampled personnel files reviewed. The "Assisted Living and Resident Care	C6000		

Oklahoma State Department of Health

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C6000	Continued From page 12 Overview" form, dated 04/16/24, documented 37 residents resided in the center. Findings: An undated staff roster, documented CMA #1, CNA #1, and CNA #2 were hired on 09/11/23. There was no documentation registry screening and background checks were completed until 02/02/24. On 04/17/24 at 11:40 a.m., the administrator/LPN was asked if registry checks and background checks were completed when CNA #1, CNA #2, and CMA #1 were hired. They stated all three of the staff worked together at another center before being hired. They stated registry screening and background checks were not cheked when they were hired. They stated they caught that they had not been completed and they completed the screening and checks in February 2024.	C6000		

Delivery via email to: lpn_583@yahoo.com

May 23, 2024

License Number: AL2502

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

RE: Survey Event OLIT11

Dear Ms. Vandever:

On **April 18, 2024**, agents from our office completed a Relicensure survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **The correction dates are unacceptably long for item(s) C-0391: [The correction date of July 5, 2024, is outside of sixty \(60\) days.](#)**

Please resubmit a new plan of correction, with amendments, as soon as possible.

Respectfully,

Tempal Killman

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

Enclosure

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 5/13/2024	
	Facility Name: The Willows Assisted Living Residence	
	License Number: AL2502	
	Survey Event ID: OLIT11	
Date Survey Completed: 4/18/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C391	Based on: Based on observation and interview, the center failed to ensure proper food service sanitation requirements were followed.	
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?	Inservicing and training was provided with all dietary staff. Thorough cleaning of floors and surfaces in the kitchen and walk in cooler and freezer was discussed as well as labeling of all necessary food items. Dietary staff will clean these areas without fail no fewer than 3 times a week. This will include the walk in freezer, making sure to organize items appropriately making sure unpasteurized eggs are placed below and not near or close to cheese, fresh food or produce. The walk in freezer will be observed for ice build up. If ice is present, dietary worker will remove the ice no later than the end of the shift in which ice is observed. All maintenance concerns, including the need for repair of the gaskets on the prep cooler, broken or missing light shields, and the metal spray nozzle located on the three compartment sink have all been reported to maintenance personal and are currently be repaired. All staff have been inserviced to always label cleaning solutions and to keep these solutions away from the drink station area when not in use. A clean cloth will be used for wiping down surfaces. Soiled and damp clothes shall be placed in the dirty aundry basket for proper washing and disinfecting.	
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 lives at the facility and who receives meals in our facility can be considered at possible risk.	
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?	Visual inspection of the kitchen and food storage area will be conducted weekly by the administrator. Thorough cleaning of all floors and surfaces with be done no fewer than three times a week by dietary staff. Ice will be removed by dietary staff by the end of the shift in which it was observed. Any issues of uncleanliness will be addressed immediately. Maintenance concerns will be reported as soon as they are recognized to ensure prompt repair.	

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) Floors and surfaces will be monitored by visual inspection each week by the administrator. The kitchen and dry storage area will be visually inspected as well to determine the need for any repairs to equipment or fixtures. b) Cleaning efficiency and repairs made or needing to be made will be provided and discussed at each quarterly quality assurance meeting. Quality assurance members will be provided records maintained by dietary staff and administrator for approval. c) Cleaning will be documented in a spiral notebook by the dietary staff. The weekly visual inspections made by the administrator will also be documented in this notebook. Date, time and initials as well as a description of what was done will be required documentation by dietary staff each shift. A maintenance log will be put in place to document any repair that is needed. This documentation shall include repair needed, date repair is reported to maintenance and date repair is completed. 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?	7/5/2024		
OSDH Response: Element accepted Yes ☐ No ☐			
<table border="1"> <tr> <td> Administrator's Signature Dana Vandever, Administrator OAC 310:663-25-4(F) </td> <td>Date 5/13/2024</td> </tr> </table>		Administrator's Signature Dana Vandever, Administrator OAC 310:663-25-4(F)	Date 5/13/2024
Administrator's Signature Dana Vandever, Administrator OAC 310:663-25-4(F)	Date 5/13/2024		
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.		
Submitted by	Enter name of person submitting addendum.		
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 5/13/2024	
	Facility Name: The Willows Assisted Living Residence	
	License Number: AL2502	
	Survey Event ID: OLIT11	
Date Survey Completed: 4/18/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C913	Based on: Observation, record review, and interview, the center failed to ensure accuracy of DNR orders for five (#4,5,6,7 and #8) of eight sampled residents reviewed for code status.	
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?		All resident charts have been reviewed and updated to reflect the accurate code status of each resident. This was completed on 4/19/2024. All future residents who wish to have a DNR code status will be required to provide a properly witnessed, dated and signed DNR form upon admission. If the DNR form is not provided, the residents chart will not be flagged with a DNR code status label. A notice of such requirement will be placed in all admission packets. The administrator has personally counseled the administrative assistant and the RN consultant regarding what is required in order for our facility to label a residents chart with the DNR code status label.
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; current and future, living in the assisted living residence are at risk for potential mislabeling of code status without these changes.
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 admission packets will now contain a notice that reads Attention A properly completed DNR form must be provided at the time of admission in order for our facility to honor the resident's wish as a DNR code status. Without the properly completed form, we have no choice but to view the resident as a full code and all necessary measures will be taken. All current resident charts have been reviewed, updated and corrected if needed to ensure all Code Status's are accurate. Future charts will be reviewed monthly to ensure labeling is not been damaged or missing.
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;		a)Each chart will be reviewed for proper Code Status once a month. If the chart does contain the properly completed form, the chart will be labeled with a bright orange DNR label. If the chart does not contain the completed DNR form and the accompanied paperwork is conflicting, all

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.		conflicting items will be corrected to reflect that the DNR form has not been provided. b) A code status logsheet will be created to quickly identify which resident's have the DNR code status. This logsheet will contain the resident's name, apartment number, code status, and if the DNR form is on file in the resident's chart. This flowsheet will be updated each month to reflect any changes in code status if necessary c) This code status flowsheet will be presented for review at each quarterly quality assurance meeting. 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?		5/31/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Dana Vandever, Administrator OAC 310:663-25-4(F)		Date 5/13/2024	
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Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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Facility in Compliance by: Click here to enter a date.			



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/13/2024

Facility Name: The Willows Assisted Living Residence

License Number: AL2502

Survey Event ID: OLIT11

Date Survey Completed: 4/18/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C952

Based on: record review and interview, the center failed to ensure the designated activities staff member was qualified by training to provide activities.

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

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 ☐

Administrator's Signature Dana Vandever

OAC 310:663-25-4(F)

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Since the date of survey, the staff member in charge of activities has completed an online activities coordinator training course and has received proof of training. This training will provide residents

Every resident living at The Willows Assisted Living is considered potentially affected. All residents participate occasionally in the activities provided and as such are identified as affected.

Proof of proper training will be required prior to employment in that role as we go forward. When and if that role becomes available in the future, the person considered for the job will be required to complete training and provide the completion certificate before they are allowed to assume the position.

Proof of certification in activities coordination will be required. a) requiring proof of certification prior to employment will ensure effectiveness. b) the quality assurance committee will review proper certification for all employees including the activity coordinator. This review will be completed at each quarterly meeting. c) proper certification will be placed in the employees file and will be available for review at all times.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

5/3/2024

Date 5/13/2024

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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Items Below Are For OSDH Use Only

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

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Facility in Compliance by: Click here to enter a date.

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 5/13/2024	
	Facility Name: The Willows Assisted Living Residence	
	License Number: AL2502	
	Survey Event ID: OLIT11	
Date Survey Completed: 4/18/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1110	Based on: record review and interview, the center failed to ensure the QA committee met on a quarterly basis	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: The Willows Assisted Living takes QA meetings seriously. Our committee is comprised of professionals who are selfless in donating their time to attend quarterly. The QA meeting that did not occur at the end of March 2024 was due to scheduling conflicts and vacation plans by a couple of the members. The meeting had already been rescheduled to 4/26/2024. The surveyor was informed of the scheduled date for the meeting at the time of survey.		
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?		Quality Assurance meetings will be held each quarter as required. Meetings will be scheduled earlier in the month to ensure that if a meeting must be rescheduled it can still be held within the appropriate time frame.
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 resident's residing in an Assisted Living residence have the potential of being affected. Quality Assurance meetings are necessary to ensure that important issues are discussed and dealt with to provide a safe and healthy living experience for our residents.
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?		Meetings that must be rescheduled will be done so as to still occur in the appropriate time frame. All QA meetings will, without fail, be held prior to the end of each quarter. Notice of scheduled meetings will be made in an effort to ensure any postponement not violate the quarterly time frame as required.
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) In the QA meeting that was held on 4/26/2024, the rescheduled meeting that created this survey tag was discussed. Each member expressed understanding and willingness to make every effort to attend QA meetings as scheduled to ensure the quarterly time frame is maintained. b) This correction will be met by the evidenced documentation and proof of QA meetings that will be kept of all quarterly meetings. c) Dated QA meeting agenda's with a list of the members in attendance will be kept in a labeled folder kept in the administrators office filing cabinet. 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?		4/26/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Dana Vandever OAC 310:663-25-4(F)		Date 5/13/2024	
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 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 5/13/2024	
	Facility Name: The Willows Assisted Living Residence	
	License Number: AL2502	
	Survey Event ID: OLIT11	
Date Survey Completed: 4/18/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C6000	Based on: record review and interview, the center failed to conduct registry screening and background checks for staff upon hire for three (CMA#1, CAN#1, CAN#2) of five sampled personnel files reviewed.	
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?		The Willows Assisted Living will only allow a new employee to have direct patient access only after proper screening has been completed and a criminal history record check has been completed.
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 and all resident's receiving care from an improperly screened employee is at potential risk.
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 administrator will now be the one to conduct all required screening for new employees. The oversight was caught after the departure of the administrative assistant who had previously been in charge of the screening process. I will personally make sure all future screening is complete before a new employee is scheduled to work.
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)By completing the screening process of future employees prior to them being allowed to work will ensure that this correction is effective. b) An employee roster with hire date and screening completion date will be presented and reviewed at each quarterly quality assurance meeting. c) The administrator will place all supporting screening documents in the employee file. The date of clearance and eligibility for hire will be documented in the employees chart. Only then will that individual be allowed to work. 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?		4/26/2024
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Dana Vandever		Date 5/13/2024

OAC 310:663-25-4(F)			
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Facility in Compliance by: Click here to enter a date.			

Delivery via email to: Dana Vandever <lpn_583@yahoo.com>

May 30, 2024

License Number: AL2502

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

RE: Survey Event OLIT11

Dear Ms. Vandever:

On **April 18, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your 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 **June 15, 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,



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

Enclosure

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 5/24/2024	
	Facility Name: The Willows Assisted Living Residence	
	License Number: AL2502	
	Survey Event ID: OLIT11	
Date Survey Completed: 4/18/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C319	Based on: Based on observation and interview, the center failed to ensure proper food service sanitation requirements were followed.	
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?	Inservicing and training was provided with all dietary staff. Thorough cleaning of floors and surfaces in the kitchen and walk in cooler and freezer was discussed as well as labeling of all necessary food items. Dietary staff will clean these areas without fail no fewer than 3 times a week. This will include the walk in freezer, making sure to organize items appropriately making sure unpasteurized eggs are placed below and not near or close to cheese, fresh food or produce. The walk in freezer will be observed for ice build up. If ice is present, dietary worker will remove the ice no later than the end of the shift in which ice is observed. All maintenance concerns, including the need for repair of the gaskets on the prep cooler, broken or missing light shields, and the metal spray nozzle located on the three compartment sink have all been reported to maintenance personal and are currently be repaired. All staff have been inserviced to always label cleaning solutions and to keep these solutions away from the drink station area when not in use. A clean cloth will be used for wiping down surfaces. Soiled and damp clothes shall be placed in the dirty aundry basket for proper washing and disinfecting.	
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 lives at the facility and who receives meals in our facility can be considered at possible risk.	
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?	Visual inspection of the kitchen and food storage area will be conducted weekly by the administrator. Thorough cleaning of all floors and surfaces with be done no fewer than three times a week by dietary staff. Ice will be removed by dietary staff by the end of the shift in which it was observed. Any issues of uncleanliness will be addressed immediately. Maintenance concerns will be reported as soon as they are recognized to ensure prompt repair.	

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) Floors and surfaces will be monitored by visual inspection each week by the administrator. The kitchen and dry storage area will be visually inspected as well to determine the need for any repairs to equipment or fixtures. b) Cleaning efficiency and repairs made or needing to be made will be provided and discussed at each quarterly quality assurance meeting. Quality assurance members will be provided records maintained by dietary staff and administrator for approval. c) Cleaning will be documented in a spiral notebook by the dietary staff. The weekly visual inspections made by the administrator will also be documented in this notebook. Date, time and initials as well as a description of what was done will be required documentation by dietary staff each shift. A maintenance log will be put in place to document any repair that is needed. This documentation shall include repair needed, date repair is reported to maintenance and date repair is completed. 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?	6/15/2024		
OSDH Response: Element accepted Yes ☐ No ☐			
<table border="1"> <tr> <td> Administrator's Signature Dana Vandever, Administrator OAC 310:663-25-4(F) </td> <td>Date 5/24/2024</td> </tr> </table>		Administrator's Signature Dana Vandever, Administrator OAC 310:663-25-4(F)	Date 5/24/2024
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Facility in Compliance by: Click here to enter a date.			

Delivery via email to: lpn_583@yahoo.com

September 5, 2024

License Number: AL2502

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

RE: Survey Event OLIT12

Dear Ms. Vandever:

On **September 4, 2024**, 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 **April 18, 2024**, have now been corrected effective **June 15, 2024**.

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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: AL2502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/04/2024
NAME OF PROVIDER OR SUPPLIER THE WILLOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 On 09/04/24, an offsite/revisit was conducted. The deficiencies from 04/18/24 were cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE