
Delivery via email to: lpn_583@yahoo.com

November 19, 2025

License Number: AL2502

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

RE: Survey Event ID: COMI11

Dear Ms. Vandever:

On **November 7, 2025**, 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.

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 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

INVESTIGATIVE REPORT

Facility: THE WILLOWS
Address: 301 MELVILLE DRIVE
City, State, Zip: PAULS VALLEY, OK 73075
Provider #: AL2502
Complaint #: OK00085765
Investigation Date(s): 11/04/25 through 11/07/25

ALLEGATION(S)
The facility failed to have an effective pest control program.

An unannounced on-site investigation was initiated 11/04/2025 at 8:11 a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Resident rooms were observed for pest activity.

Facility policy and procedures were reviewed. Pest control invoices reviewed.

Residents were interviewed regarding pests in the facility. Staff were interviewed regarding facility policy and procedure related to pest control.

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: 11/10/2025

INVESTIGATIVE REPORT

Facility: THE WILLOWS
Address: 301 MELVILLE DRIVE
City, State, Zip: PAULS VALLEY, OK 73075
Provider #: AL2502
Complaint #: OK00086036
Investigation Date(s): 11/04/25 through 11/07/25

ALLEGATION(S)
The facility failed to have an effective pest control program.

An unannounced on-site investigation was initiated 11/04/2025 at 8:11 a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Resident rooms were observed for pest activity.

Facility policy and procedures were reviewed. Pest control invoices reviewed.

Residents were interviewed regarding pests in the facility. Staff were interviewed regarding facility policy and procedure related to pest control.

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: 11/10/2025

INVESTIGATIVE REPORT

Facility: THE WILLOWS
Address: 301 MELVILLE DRIVE
City, State, Zip: PAULS VALLEY, OK 73075
Provider #: AL2502
Complaint #: OK00086847
Investigation Date(s): 11/04/25 through 11/07/25

ALLEGATION(S)
The facility failed to ensure staff were qualified/licensed to administer medications and provide wound care.
The facility failed to ensure medications were administered according to policy and procedure
The facility failed to maintain an effective pest control program.
The facility failed to ensure a registered dietician provided oversight of menus and meals.
The facility failed to ensure activities staff completed training.
The facility failed to ensure residents were not above the level of care.
The facility failed to ensure the Administrator was available to provide oversight.

An unannounced on-site investigation was initiated 11/04/2025 at 8:11 a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Resident rooms were observed for pest activity, staff observed administering medications, residents observed taking medications, activities observed, residents observed for level of care, and the administrator's presence observed.

Facility policy and procedures were reviewed. Staff notes, physician orders, resident assessments, hospital records, employee records, pest control invoices, and state reportable incidents were reviewed.

Residents were interviewed regarding medications administration, staff qualification to care for them, pests, meals, activities, care needs, and administrator interactions. Staff were interviewed regarding facility policy and procedure related to medication administration, staff qualification, pests, meals, activities, care needs, and administrator oversight.

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: 11/10/2025

INVESTIGATIVE REPORT

Facility: THE WILLOWS
Address: 301 MELVILLE DRIVE
City, State, Zip: PAULS VALLEY, OK 73075
Provider #: AL2502
Complaint #: OK00087363
Investigation Date(s): 11/04/25 through 11/07/25

ALLEGATION(S)
The facility failed to ensure staff followed their policy and procedure for safe administration of medications.
The facility failed to ensure staff were provided CPR training.
The facility failed to ensure unqualified staff did not provide direct care to the residents.
The facility failed to ensure an Administrator was available to oversee daily operations of the facility
The facility failed to ensure Licensed supervision for a medication aide while training on the medication cart.

An unannounced on-site investigation was initiated 11/04/2025 at 8:11 a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Staff observed administering medications, residents observed taking medications, staff observed during day to day care, and the administrator's presence observed.

Facility policy and procedures were reviewed. Staff notes, physician orders, resident assessments, hospital records, employee records, and state reportable incidents were reviewed.

Residents were interviewed regarding medications administration, staff qualification to care for them, and administrator interactions. Staff were interviewed regarding facility policy and procedure related to medication administration, staff qualification, and administrator oversight.

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: 11/10/2025

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 C 11/07/2025
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 Complaint investigations (#OK00085765, OK00086036, OK00086847, and #OK00087363) were conducted on 11/04/25 through 11/07/25. Deficiencies were cited as a result of the survey. Facility Census: 33 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide CNA- certified nurse aide MG- milligram LPN- license practical nurse MAT- medication aide technician RN- registered nurse	C 000		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a resident's service plan was updated annually to reflect their service level needs for 1 (#6) of 8 sampled residents whose service plans were reviewed. The administrator identified 33 residents resided in the center.	C 552		

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 552	Continued From page 1 Findings: A "RESIDENT ASSESSMENT" for service level, dated 04/25/22, showed Resident #6's service level was one (least level of care needs). The assessment showed the resident was independent for mobility, personal hygiene, bathing, housekeeping, and laundry. The assessment showed the resident was oriented with occasional forgetfulness. An annual "Assisted Living Resident Assessment Form," dated 04/25/25, showed Resident #6 was admitted to the center on 04/25/22 and had diagnoses which included arthritis, weight loss, and cognitive decline. The assessment showed the resident required one person assistance with bathing, eating, dressing, transferring, and toileting. The assessment showed Resident #6 was oriented times one (to self). On 11/05/25 at 10:24 a.m., Resident #6's private care giver stated the resident needed one person assistance with activities of daily living such as bathing, hygiene, toileting, and transfers. They stated the resident was oriented to self. On 11/05/25 at 12:54 p.m., the administrator stated Resident #6 did not have an updated service plan with care level assessment. They stated it was to be updated annually. On 11/05/25 at 4:29 p.m., the RN consultant stated they were responsible for yearly update on service plans. On 11/05/25 at 4:30 p.m., the RN consultant stated Resident #6's service level should be a	C 552		

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C 552	Continued From page 2 three (highest level of care needs).	C 552		
C 921 SS=D	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure a certified medication aide had an active license to administer medications for 1 (CMA #3) of 7 medication aides whose records were reviewed for qualifications. The administrator identified 33 residents resided in the center. Findings: A "Caregiving and Medication Administration" policy, dated 08/04/04, read in part, "Medications will be administered by center staff trained and certified in medication administration. MAT or CMA certified staff or LPN or higher are acceptable." A review of CMA #3's employee record showed their certified medication aide certification expired on 10/31/25.	C 921		

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C 921	Continued From page 3 The "WILLOWS EMPLOYEE WORK SCHEDULE" for 11/02/25 through 11/08/25, showed CMA #3 worked on 11/02/25, 11/03/25, and 11/04/25 as a medication aide. On 11/05/25 at 11:43 a.m., the administrator stated CMA #3's certification expired on 10/31/25. On 11/05/25 at 11:45 a.m., the administrator stated CMA #3 worked on 11/02/25 through 11/04/25 as a medication aide. On 11/07/25 at 4:12 p.m., CMA #3 stated they worked on the medication cart on 11/02/25 through 11/04/25. They stated they did not realize their certification had expired.	C 921		
C1505 SS=J	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	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 4 treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: On 11/05/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the center's failure to ensure Resident #2 received the correct medications by a qualified staff. Resident #2 became hypotensive and received treatment in an intensive care unit. On 11/05/25 at 4:41 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On 11/05/25 at 5:25 p.m., the administrator was notified of the IJ situation and the IJ template was provided. On 11/06/25 at 12:01 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 5 "Plan of Removal November 6, 2025 This plan of Removal addresses a medication error on 10/30/2026 [sic] [2025]. 1. There will be a mandatory staff inservice to educate Willows staff on proper procedure when administering medication at 4p.m. Friday November 7, 2025 by [name withheld], RN consultant. Specifically: 1. Who administers the medication 2. Verifying it's the correct resident 3. View and verifying the resident takes the medication 2. Educate staff that only those licensed or certified to administer medications are allowed to handle medications. 3. If a medication error occurs - who should be notified of the error and when? The nurse on call should always be notified (the nurse will advise of any additional individuals who need to be contacted 4. A team meeting will to take place to educate administrative staff on the need to notify the appropriate individuals and agencies when such an error occurs. This meeting will take place November 7, 2025 at 3p.m. Plan of Removal will be completed by 5p.m. on November 7, 2025." The IJ was lifted, effective 11/07/25, when all components of the plan of removal had been	C1505		

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C1505	Continued From page 6 verified as completed. Staff on different shifts were interviewed regarding the procedure for medication administration, who was allowed to administer medications, and process for medication errors. Staff were able to verbalize understanding of the above process. The deficiency remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the center failed to ensure a resident received the correct medications by a qualified staff for 1 (#2) of 3 sampled residents reviewed for medication administration. The administrator identified 33 residents resided in the center. Findings: A "Caregiving and Medication Administration" policy, dated 08/04/04, read in part, "Medications will be administered by center staff trained and certified in medication administration. MAT or CMA certified staff or LPN or higher are acceptable." An undated facility "MEDICATION ADMINISTRATION ERRORS" policy, read in part, "In the event of a medication error, immediate action is taken as necessary to protect the resident's safety and welfare"... "If the resident is in any apparent distress, notify the resident's physician, report on the status of the resident, and follow the instructions of the physician"... "If the resident is not in distress, check the resident every 15 minutes for one hour and once every hour thereafter until instructions are received from the physician"... "Notify the resident's family/responsible party and report on the status	C1505		

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C1505	Continued From page 7 of the resident"...Complete and submit the Medication Error Report"...Perform the appropriate follow-up to medication errors as part of THE WILLOWS quality assurance and continuous quality improvement program." An undated facility "DEFINITION OF MEDICATION ADMINISTRATION ERRORS" policy, read in part, "Unauthorized Drug Error-The administration of a medication or taking of a medication by a resident without a physician's order." An annual "Assisted Living Resident Assessment Form," dated 08/10/25, showed Resident #2 had diagnoses which included congestive heart failure and chronic kidney disease. The assessment showed the resident was alert with forgetfulness at times. The assessment showed the resident had home health services with physical therapy for right sided weakness. Resident #2's plan of service, dated 08/10/25, showed nursing staff were to administer the resident's medications. Resident #2's "Medication Sheet" for October 2025, showed the following physician orders: a. midodrine (an antihypotensive medication) 10 mg take one tablet by mouth after meals, dated 08/11/22; and b. metoprolol (an antihypertensive medication) 25 mg extended release, take one half tablet to equal 12.5 mg by mouth daily for hypertension, dated 10/12/23. The medication sheet showed Resident #2 received metoprolol at 8:00 am on 10/30/25. A "MEDICATION ERROR OR REACTION REPORT," dated 10/30/25 at 7:50 p.m., showed	C1505		

Oklahoma State Department of Health

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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
C1505	Continued From page 8 Resident #2 was given medications that belonged to Resident #7. The report showed the resident received lisinopril (an antihypertensive medication) 5 mg, metoprolol (an antihypertensive medication) 50 mg, trazodone (an antidepressant medication) 50 mg, amiodarone (an antiarrhythmic medication) 200 mg, baclofen (a muscle relaxer medication) 10 mg, Lamictal (an anticonvulsant medication) 75 mg, pregabalin (an anticonvulsant medication) 200 mg, Eliquis (an anticoagulant medication) 5 mg, Eliquis 2.5 mg, atorvastatin (an anticholesterol medication) 20 mg, montelukast (a medication used to treat inflammation) 10 mg, and tamsulosin (a medication used to treat prostate diagnosis) 0.4 mg. The report did not show the resident's physician was notified. An "ACCIDENT/INCIDENT REPORT," dated 10/30/25 at 7:50 p.m., read in part, "[CNA #1] was following [CMA #1] doing 8pm medication. [CMA #1] handed [CNA #1] a medicine cup [with] [Resident #7's] medications. [Gender withheld] asked [CNA #1] to hand to resident. [CNA #1] went to [Resident #2's] door, asked if it was the right place. [CMA #1] nodded and said yes so [CNA #1] gave [Resident #2] what [CNA #1] thought was their medication when they were [Resident #7's]." Resident #2's hospital record, dated 10/31/25, showed admission diagnoses which included accidental overdose and hypotension. The record showed the resident had a pacemaker. The record showed the resident's blood pressure dropped as low as 57/47 and the resident received vasopressors (anti-hypotension medication) and fluids. On 11/04/25 at 11:39 a.m., Resident #2 stated	C1505		

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 C 11/07/2025
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
C1505	Continued From page 9 they went to the hospital last week because they received the wrong medication. They stated they do not know all the medications they took at the facility. On 11/04/25 at 1:15 p.m., CMA #2 stated they started their shift at 10:00 p.m. on 10/30/25. They stated Resident #2 had complained of being dizzy with blurry vision when they tried to get them in bed. They stated they were informed of the medication error. CMA #2 stated the resident's blood pressure dropped to 62/48 on 10/31/25 and the resident was lethargic when the paramedics arrived at the center. On 11/04/25 at 2:36 p.m., CMA #1 stated the medication rights were the right person, right medication, right time, right route, right dose, right to refuse, documentation, and education. On 11/04/25 at 2:37 p.m., CMA #1 stated CNA #1 was observing them during medication pass around 8:00 p.m. on 10/30/25. They stated CNA #1 observed them punch Resident #7's medications. CMA #1 stated they instructed CNA #1 to give Resident #7's medications and they proceeded to look at resident charts and did not observe CNA #1 administer the medications. They stated it was their mistake. CMA #1 stated when CNA #1 came out, they instructed them to give Resident #2 their medications and CNA #1 informed them they gave Resident #2 their medications. CMA #1 stated they informed CNA #1 the medications were for Resident #7. On 11/04/25 at 2:46 p.m., CMA #1 stated they gave Resident #2 amiodarone 200 mg one tablet, atorvastatin 20 mg one tablet, lisinopril 5 mg one tablet, metoprolol 50 mg one tablet, montelukast 10 mg one tablet, trazodone 50 mg one tablet,	C1505			

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 C 11/07/2025
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
C1505	Continued From page 10 Eliquis 5 mg one tablet, Eliquis 2.5 mg one tablet, pregabalin 200 mg one tablet, tamsulosin 0.4 mg one tablet, baclofen 10 mg one tablet, and Lamictal 25 mg, three tablets to equal 75 mg. On 11/04/25 at 2:49 p.m., CMA #1 stated Resident #2 took metoprolol 25 mg daily in the morning. On 11/04/25 at 2:52 p.m., CMA #1 stated Resident #2 took midodrine 10 mg three times a day to raise their blood pressure. On 11/04/25 at 2:55 p.m., CMA #1 stated CNA #1 was getting their MAT certification and were only supposed to observe medication administration. On 11/04/25 at 2:57 p.m., CMA #1 stated they notified the administrator, the registered nurse consultant, and the resident of the medication error. On 11/04/25 at 3:04 p.m., CMA #1 stated they did not follow the medication administration process. They stated they did not receive an in-service or education after the incident on 10/30/25. On 11/04/25 at 3:16 p.m., the administrator stated CNA #1 was hired to work on the medication cart at night and was doing shadow training with CMA #1. They stated CNA #1 was in a refresher course to get their MAT updated. The administrator stated CNA #1 gave Resident #7's medications to Resident #2 on 10/30/25. The facility did not have CNA #1's certification to administer medications. On 11/04/25 at 5:04 p.m., CNA #1 stated they were to update their MAT certifications. They	C1505		

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 C 11/07/2025
NAME OF PROVIDER OR SUPPLIER THE WILLOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 301 MELVILLE DRIVE PAULS VALLEY, OK 73075		
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C1505	Continued From page 11 stated they were training with CMA #1 and CMA #1 asked them to give Resident #7 their medication after CMA #1 punched them. CNA #1 stated they went to Resident #2's room and asked CMA #1 if they were at the right room and CMA #1 stated yes. They stated CMA #1 was not paying attention. CNA #1 stated they gave Resident #2 the medications. They stated they were not informed they could not give medications. On 11/04/25 at 5:16 p.m., CNA #1 stated they did not receive an in-service. They stated CMA #2 had informed them to fill out an incident report and told them they should not have administered medications. On 11/05/25 at 10:15 a.m., the administrator stated they did not inform the resident's physician of the medication error. They stated there was not an actual process for physician notification. The administrator stated they should have notified the resident's physician. On 11/05/25 at 11:36 a.m., the administrator stated they did not have a MAT certificate for CNA #1. On 11/05/25 at 12:32 p.m., the home health representative stated they should be notified of any changes in a resident's condition, emergency medical service activation, hospital visit, and medication errors. On 11/05/25 at 12:34 p.m., the home health representative stated they were not notified of Resident #2's medication error and hospital visit. They stated they found out while a staff was visiting another resident at the center on 11/04/25.	C1505		

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 C 11/07/2025
NAME OF PROVIDER OR SUPPLIER THE WILLOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 301 MELVILLE DRIVE PAULS VALLEY, OK 73075		
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C1505	Continued From page 12 On 11/05/25 at 12:36 p.m., the home health representative stated they notified a resident's primary care provider of any changes in their condition. On 11/05/25 at 1:12 p.m., the administrator stated the resident's home health company was not notified of the medication error and emergency room visit. They stated they should have been notified. On 11/05/25 at 2:50 p.m., Resident #7's provider stated if the resident had already received their blood pressure medication, any additional doses would lower their blood pressure.	C1505			
C1922 SS=D	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure staff observed medications being swallowed for 1 (#8) of 2 sampled residents observed for medication administration. The administrator identified 33 residents resided in the center. Findings:	C1922			

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 C 11/07/2025
NAME OF PROVIDER OR SUPPLIER THE WILLOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 301 MELVILLE DRIVE PAULS VALLEY, OK 73075		
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C1922	Continued From page 13 On 11/06/25 at 7:56 a.m., Resident #8 was observed in the dining room eating breakfast. There was a medication cup with their name on it. They had 10 medication pills on their napkin. The napkin had three white capsules, two rose pink tablets, three white tablets, one purple and grey capsule, and one blue and white capsule. On 11/06/25 at 8:04 a.m., Resident #8 was observed to start taking their medications after counting them to 10. An annual "Assisted Living Resident Assessment Form," dated 11/06/25, showed Resident #8 had diagnoses which included hypertension and muscle weakness. The assessment showed the resident was alert and forgetful at times. Resident #8's "Medication Sheet" for November 2025, showed the following physician orders: a. amlodipine (an antihypertensive medication) 5 mg one tablet by mouth daily for hypertension, dated 03/28/19; b. magnesium oxide (a dietary supplement) 400 mg one tablet by mouth daily, dated 03/28/29; c. omeprazole (an antacid medication) 20 mg one capsule by mouth daily for acid relief, dated 03/28/19; d. clopidogrel (an antiplatelet medication) 75 mg one tablet by mouth daily to prevent stroke, dated 08/22/19; e. gabapentin (an anticonvulsant medication) 100 mg three capsules by mouth daily for neuropathy, dated 08/27/19; f. nitrofurantoin (an antibiotic medication) 50 mg one capsule by mouth every day, dated 10/25/23; g. rosuvastatin (an anticholesterol medication) 10 mg one tablet three times a week, dated 11/08/23; and	C1922		

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 C 11/07/2025
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
C1922	Continued From page 14 h. memantine (a medication used to treat Alzheimer's) 5 mg one tablet by mouth two times daily, dated 11/14/23. On 11/06/25 at 7:57 a.m., Resident #8 stated they did not know who gave them their medication. CMA #4 was not in sight. On 11/06/25 at 8:06 a.m., the surveyor had CNA #3 observe Resident #8's actions. They stated the resident was taking their medication. On 11/06/25 at 8:08 a.m., CMA #4 stated their medication administration process was to open the resident's medication administration record, verify on the medication label, pop the medication in a cup, check the information again, and move on to the next medication. They stated they would take a resident's blood pressure if applicable and administer the medications. CMA #4 stated they were to watch the residents take their medications. On 11/06/25 at 8:09 a.m., CMA #4 stated they gave Resident #8 their morning medication and did not watch them take their medication. They stated they did not follow their process.	C1922		

Delivery via email to: lpn_583@yahoo.com

December 5, 2025

License Number: AL2502

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

Survey Event ID: COM11

Dear Ms. Vandever:

On **November 7, 2025**, agents from our office completed a complaint investigation 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:

- **C552-** The plan of correction does not provide an education/in-service individual who is responsible for service plans.

Please provide a new plan of correction with amendments and return as soon as possible.

Respectfully,



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: 12/1/2025

Facility Name: The Willows Assisted Living Residence

License Number: AL2502

Survey Event ID: COMI 11

Date Survey Completed: 11/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C552

Based on: Record review and interview, the center failed to ensure a resident's service plan was updated annually to reflect their service level needs for 1(#6) of 8 sampled residents whose service plans were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

Based on the deficiency cited, the center has implemented the following corrective action:

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.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All resident charts have been reviewed and updated to reflect a current and accurate plan of service. This was completed on 11/19/2025 by the RN. An Excell spreadsheet has been created with the name of resident, date of admission, date of assessment and due date for next annual assessment. This spreadsheet will be updated after assessment is completed as well as upon admission or discharge of new and existing residents.

All residents, current and future, living in the assisted living residence are at risk for potential untimely assessments without these changes.

An Excell Spreadsheet has been implemented to list and track admission dates of all residents, date of assessment and due date for next annual assessment. This spreadsheet will be updated after an assessment is completed. The spreadsheet will be kept up to date at all times by the RN and the administrative assistant. New admissions will be added to this spreadsheet immediately upon the completion of the initial assessment. Existing residents will be updated on the spreadsheet to reflect the date of their last assessment which shall be done annually or as a residents care needs change.

A) Each resident chart will be reviewed once a month by the RN to ensure that all assessments are done in a timely manner. B) The RN will ensure that all assessments are done in a timely manner and that all assessments accurately reflect the proper level of care required for each resident. Care needs are ever changing for many residents and each care plan will be updated annually or as a residents needs change. The RN will ensure that the resident and/or their POA or next of kin is aware of any

		changes in Plan of Care and will obtain the appropriate signatures. The RN will present a copy of the Excel spreadsheet at each quarterly Quality Assurance Meeting. QA members will review and be better informed of the overall care level requirements for the total census of the facility. This information will allow a more complete and accurate understanding by our QA members of the type of care currently required as well as the type of care being preformed by our staff. C) The newly implemented Excel Spreadsheet will be maintained on the office computer by the RN and/or administrative assistant. The spreadsheet will be printed and provided to the administrator after each updated entry. A printed copy will be kept on the peg board located inside the administrators office for weekly reference to ensure all assessments are up to date. Implement a new evaluation of efficacy every Implement a new procedure into QA system Implement a new procedure for recording records.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		12/5/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Dana D. Vandever, Administrator OAC 310.663-25-4(F)		Date 12/1/2025	
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: Leave blank or enter 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 text.			



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/1/2025

Facility Name: The Willows Assisted Living Residence

License Number: AL2502

Survey Event ID: COM11

Date Survey Completed: 11/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921

Based on: record review and interview, the center failed to ensure a certified medication aide had an active license to administer medications for 1 (CMA #3) of 7 medication aides whose records were reviewed for qualifications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's response to comments or deficiencies in 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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Each CMA and MAT employee, future and present, will maintain a current and active license to administer medications while employed at The Willows Assisted Living Residence at all times. Employees who have failed to maintain a valid license will be removed from the schedule until the requirement has been met.

Any resident who is receiving medication assistance within our facility is identified as having the potential of being affected if the proper corrective measures are not taken.

Properly certified and licensed staff is a priority of The Willows Assisted Living Residence. An in-service and training meeting was held on November 25th that addressed the importance of all staff members maintaining a valid and current license at all times. A copy of our facilities Policy and Procedure pertaining to this was provided. Employees that fail to maintain a current license will be removed from the schedule until the requirement has been met. An Excel spreadsheet has been created with the names of employees, hire date, expiration date of current certifications and/or licenses. This spreadsheet will be updated each month by the administrator so that it reflects only the most up to date information.

A) The Administrator will personally create and maintain a spreadsheet that list each employee and his/or license expiration date(s). This spreadsheet will be updated each month and will be referred weekly. B) The administrator will provide this information for review at each quarterly QA meeting. Each quality assurance member will be able to inspect and approve the list. C) This spreadsheet will be located on the administrators computer and will be

correction.		updated monthly. This will be verified by the date of each update on the Excell spreadsheet.	
		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?		12/5/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Dana D. Vandever OAC 310:663-25-4(F)		Date 12/1/2025	
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

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/2/2025

Facility Name: The Willows Assisted Living Residence

License Number: AL2502

Survey Event ID: COMI11

Date Survey Completed: 11/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: record review and interview, the center failed to ensure a resident received the correct medications by a qualified staff for 1 (#2) of 3 sampled residents reviewed for medication administration

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: *See 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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A mandatory staff inservice for all medication administration staff was held on Nov. 7, 2025. The RN of our facility conducted the inservice and addressed the fact that only the CMA/MAT is to ever handle the medication. Each staff member was educated on the proper policy and procedure related to the administration of all medications. Each medication must be taken in the presence of the CMA/MAT and that no other employee shall ever carry a medication to be given to a resident. The full process must be done only by the CMA/MAT who is licensed and who has personally prepared the medication that is to be given. All employees acknowledged full understanding.

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 living in our facility who receives medication administration services is identified as having the potential of being affected if the proper corrective measures are not taken.

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?

Each CMA/MAT will be provided a copy of the facilities policy regarding proper medication administration. Each employee will be required to sign a confirmation acknowledging understanding of the policy. Each CMA/MAT will be inserviced quarterly regarding proper medication administration techniques. The RN will provide random and unannounced monthly medication pass observations to ensure that medication is being administered properly.

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

A) All CMAs and MATs will be shadowed by a licensed nurse to ensure all medication administration policies and procedures are being followed. This shadowing will be conducted each quarter by either the RN or LPN. This observation will be documented on an evaluation form. B) The documentation and evaluation forms related to this

center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		shadowing and training will be presented and reviewed at each quarterly QA meeting. C) All signed policy and procedure confirmations will be placed in each employees file. Proof of relevant inservice training related to medication administration will be kept with other inservice training materials in the binder labeled Inservice Training located in the administrators office. 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?		12/5/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Dana D. Vandever OAC 310:663-25-4(F)		Date 12/1/2025	
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.
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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 12/2/2025	
	Facility Name: The Willows Assisted Living Residence	
	License Number: AL2502	
	Survey Event ID: COMI11	
Date Survey Completed: 11/7/2025		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1922	Based on: Observation, record review, and interview, the center failed to ensure staff observed medications being swallowed by 1 (#8) of 2 sampled residents observed for medication administration.	
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 mandatory staff inservice for all medication administration staff was held on Nov. 7, 2025. The RN of our facility conducted the inservice and addressed the fact that only the CMA/MAT is to ever handle the medication. Each staff member was educated on the proper policy and procedure related to the administration of all medications. Each medication must be taken in the presence of the CMA/MAT and that no other employee shall ever carry a medication to be given to a resident. The full process must be done only by the CMA/MAT who is licensed and who has personally prepared the medication that is to be given. All employees acknowledged full understanding. As in ID tag 1505, the proper medication administration was not followed in that that the CMA did not watch one of the residents take her medication. Resident #8 is difficult with her medication and becomes agitated when she is made to be watched while taking her meds. She has a lengthy routine with her meds and wants to lay them all out, look at and count, and then take each pill individually one at a time. A meeting was held with this individual and her daughter. They were told that our policy requires that we must observe each resident as they take and swallow their medication. The resident has indicated that she will be cooperative going forward. The daughter of the resident is supportive of our policy and will encourage her mother to be compliant.
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 living in our facility who receives medication administration services is identified as having the potential of being affected if the proper corrective measures are not taken.
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		Each CMA/MAT will be provided a copy of the facilities policy regarding proper medication administration. Each

recur?		employee will be required to sign a confirmation acknowledging understanding of the policy. Each CMA/MAT will be inserviced quarterly regarding proper medication administration techniques. The RN will provide random and unannounced monthly medication pass observations to ensure that medication is being administered properly and that the CMA/MAT is observing residents take and swallow their medications.	
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) All CMAs and MATs will be shadowed by a licensed nurse to ensure all medication administration policies and procedures are being followed. This shadowing will be conducted each quarter by either the RN or LPN. This observation will be documented on an evaluation form. B) The documentation and evaluation forms related to this shadowing and training will be presented and reviewed at each quarterly QA meeting. C) All signed policy and procedure confirmations will be placed in each employee's file. Proof of relevant inservice training related to medication administration will be kept with other inservice training materials in the binder labeled Inservice Training located in the administrators office. 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?		12/5/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Dana D. Vandever OAC 310:663-25-4(F)		Date 12/1/2025	
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.			

Delivery via email to: lpn_583@yahoo.com

December 10, 2025

License Number: AL2502

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

Survey Event ID: COM11

Dear Ms. Vandever:

On **November 7, 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 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 **December 12, 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

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/1/2025

Facility Name: The Willows Assisted Living Residence

License Number: AL2502

Survey Event ID: COMI 11

Date Survey Completed: 11/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C552

Based on: Record review and interview, the center failed to ensure a resident's service plan was updated annually to reflect their service level needs for 1(#6) of 8 sampled residents whose service plans were 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

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All resident charts have been reviewed and updated to reflect a current and accurate plan of service. This was completed on 11/19/2025 by the RN. An Excel spreadsheet has been created with the name of resident, date of admission, date of assessment, level of care and due date for next annual assessment. This spreadsheet will be updated after assessment is completed as well as upon admission or discharge of new and existing residents. The administrator held an inservice the morning of Wednesday November 19th with the Director and the RN Consultant to discuss the issue of avoiding untimely assessments and the importance of the Plan of Service to be updated to reflect the care that is required and that is being provided. A discussion was had to determine the best way for this requirement to be met. It was decided that the use of an Excel Spreadsheet would be useful and would be implemented. It was also determined that an entirely new Plan of Service will need to be completed to provide a streamed line approach to the verification process. Simply writing in a new date on an old Plan of Service and Assessment Form will not be permitted going forward. A new Plan of Care will be completed in its entirety each time a resident is due for or is in need of reevaluation and/or assessment. Resident assessments and Plan of Service is the responsibility of the RN Consultant and therefore the Excel Spreadsheet will be created and maintained by the RN Consultant with the assistance of the Administrative Assistant. The Spreadsheet will be updated immediately after each assessment to reflect accurate and timely assessments and appropriate level of care. A copy of the updated spreadsheet will be provided to the administrator to be reviewed. This will allow the administrator to be aware of any change in level of care that is required for our residents.

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 untimely assessments 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?	An Excel Spreadsheet has been implemented to list and track admission dates of all residents, level of care, date of assessment and due date for next annual assessment. This spreadsheet will be updated after an assessment is completed. The spreadsheet will be kept up to date at all times by the RN and the administrative assistant. New forms will be completed for each assessment and Plan of Service going forward. Old forms will NOT simply be signed, dated and addendums added to update forms. New admissions will be added to this spreadsheet immediately upon the completion of the initial assessment. Existing residents will be updated on the spreadsheet to reflect the date of their last assessment which shall be done annually or as a residents care needs change.
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) Each resident chart will be reviewed once a month by the RN to ensure that all assessments are done in a timely manner. B) The RN will ensure that all assessments are done in a timely manner and that all assessments accurately reflect the proper level of care required for each resident. Care needs are ever changing for many residents and each Plan of Service will be updated annually or as a residents needs change. The RN will ensure that the resident and/or their POA or next of kin is aware of any changes in Plan of Service and will obtain the appropriate signatures. The RN will present a copy of the Excel spreadsheet at each quarterly Quality Assurance Meeting. QA members will review and be better informed of the overall care level requirements for the total census of the facility. This information will allow a more complete and accurate understanding by our QA members of the type of care currently required as well as the type of care being performed by our staff. C) The newly implemented Excel Spreadsheet will be maintained on the office computer by the RN and/or administrative assistant. The spreadsheet will be printed and provided to the administrator after each updated entry. Any resident who has required a change in Level of Care will be highlighted on the spreadsheet. This will prompt the administrator to familiarize herself with the updated Plan of Service and the reason(s) prompting the change of level of care. The administrator will then be able to update contract details and ensure that requirement is also being met. A printed copy will be kept on the peg board located inside the administrators office for weekly reference to ensure all

		assessments are up to date.	
		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?		12/12/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature		Dana D. Vandever, Administrator	Date 12/1/2025
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	12/9/2025	Submitted by	Dana D. Vandever
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: 12/1/2025

Facility Name: The Willows Assisted Living Residence

License Number: AL2502

Survey Event ID: COM11

Date Survey Completed: 11/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921

Based on: record review and interview, the center failed to ensure a certified medication aide had an active license to administer medications for 1 (CMA #3) of 7 medication aides whose records were reviewed for qualifications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's response to comments or deficiencies in 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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Each CMA and MAT employee, future and present, will maintain a current and active license to administer medications while employed at The Willows Assisted Living Residence at all times. Employees who have failed to maintain a valid license will be removed from the schedule until the requirement has been met.

Any resident who is receiving medication assistance within our facility is identified as having the potential of being affected if the proper corrective measures are not taken.

Properly certified and licensed staff is a priority of The Willows Assisted Living Residence. An in-service and training meeting was held on November 25th that addressed the importance of all staff members maintaining a valid and current license at all times. A copy of our facilities Policy and Procedure pertaining to this was provided. Employees that fail to maintain a current license will be removed from the schedule until the requirement has been met. An Excel spreadsheet has been created with the names of employees, hire date, expiration date of current certifications and/or licenses. This spreadsheet will be updated each month by the administrator so that it reflects only the most up to date information.

A) The Administrator will personally create and maintain a spreadsheet that list each employee and his/or license expiration date(s). This spreadsheet will be updated each month and will be referred weekly. B) The administrator will provide this information for review at each quarterly QA meeting. Each quality assurance member will be able to inspect and approve the list. C) This spreadsheet will be located on the administrators computer and will be

correction.		updated monthly. This will be verified by the date of each update on the Excell spreadsheet.	
		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?		12/5/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Dana D. Vandever OAC 310:663-25-4(F)		Date 12/1/2025	
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.
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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: 12/2/2025

Facility Name: The Willows Assisted Living Residence

License Number: AL2502

Survey Event ID: COMI11

Date Survey Completed: 11/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: record review and interview, the center failed to ensure a resident received the correct medications by a qualified staff for 1 (#2) of 3 sampled residents reviewed for medication administration

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: *See 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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A mandatory staff inservice for all medication administration staff was held on Nov. 7, 2025. The RN of our facility conducted the inservice and addressed the fact that only the CMA/MAT is to ever handle the medication. Each staff member was educated on the proper policy and procedure related to the administration of all medications. Each medication must be taken in the presence of the CMA/MAT and that no other employee shall ever carry a medication to be given to a resident. The full process must be done only by the CMA/MAT who is licensed and who has personally prepared the medication that is to be given. All employees acknowledged full understanding.

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 living in our facility who receives medication administration services is identified as having the potential of being affected if the proper corrective measures are not taken.

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?

Each CMA/MAT will be provided a copy of the facilities policy regarding proper medication administration. Each employee will be required to sign a confirmation acknowledging understanding of the policy. Each CMA/MAT will be inserviced quarterly regarding proper medication administration techniques. The RN will provide random and unannounced monthly medication pass observations to ensure that medication is being administered properly.

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

A) All CMAs and MATs will be shadowed by a licensed nurse to ensure all medication administration policies and procedures are being followed. This shadowing will be conducted each quarter by either the RN or LPN. This observation will be documented on an evaluation form. B) The documentation and evaluation forms related to this