OKLAHOMA
State Department
of Health

Delivery via email to: dajohnson@ireg.us

March 21, 2025

License Number: AL5595

Ms. Danna Johnson, Administrator
Town Village Assisted Living
13000 North May Avenue
Nichols Hills, OK 73120

RE: Survey Event ID: L4KN11

Dear Ms. Johnson:

On **March 7, 2025**, agents from our office concluded a State Licensure survey with complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **March 7, 2025**.

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:

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,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility:
Address:
City, State, Zip:
Provider #:
Complaint #:
Investigation Date(s):

ALLEGATION(S)
The facility failed to protect residents from retaliation for voicing grievances.
The center failed to ensure charges for services were as per residents' contract.
The facility failed to follow medication administration policies and procedures.
The center failed to notify family of a change in condition.
The center failed to maintain a clean, safe, and homelike environment.
The center failed to properly dispose of items soiled with human waste and to ensure medical equipment was clean.
The center failed to ensure incontinent care was properly provided.
The center failed to protect residents from abuse.

An unannounced on-site investigation was initiated 03/03/2025 at 07:45 a.m.

A sample of 9 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:
All policies and records, interviews with residents and staff, and observations were made pertaining to allegations. Interviews were conducted across differing staff titles and differing residents. Observations were made throughout the facility in differing apartments and common areas. Two deficiencies were cited related to this investigation.

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: 03/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5595	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWN VILLAGE ASSISTED LIVING	13000 NORTH MAY AVENUE NICHOLS HILLS, OK 73120

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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 maintain a clean and sanitary kitchen. The administrator identified 32 residents received nutrition from the kitchen. Findings: On 03/03/25 at 8:20 a.m. the dishwashing area was observed: a. there were dirty dishes from the dinner meal served on 03/02/25, b. used gloves were on the floor next to trash can,	C 391		

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C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the	C1505		

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C1505	Continued From page 2 resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to: a. store nebulizer equipment according to standards of practice for 1 (#9) of 4 sampled residents who received breathing treatments; and b. notify a resident's representative of radiological results in a timely manner for 1 (#1) of 9 sampled residents charts reviewed for representative notifications. The administrator identified 32 residents resided in the center.	C1505		

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C1505	Continued From page 3 Findings: 1. On 03/06/25 at 12:22 p.m. Resident #9's nebulizer mouth pieces were observed lying on a paper towel next to the kitchenette sink in the resident's apartment. No storage bag or box was observed. Resident #9 had diagnoses which included dementia, pulmonary fibrosis, diabetes mellitus type 2, neuropathy, benign prostate hypertrophy, essential hypertension, osteoarthritis, senile degeneration of the brain, and gastroesophageal reflux disease. Resident #9's medication list, dated 08/06/24, showed the resident was to receive albuterol sulfate 1.25 milligram/3 milliliter, "inhale 3 ml(s) via nebulizer twice daily." The electronic medication administration record for the resident showed the resident received their breathing treatments at 8:00 a.m. and 8:00 p.m. On 03/06/25 at 2:10 p.m., CMA #1 was asked what were the proper cleaning and storage of nebulizer pieces. CMA #1 stated, "Rinse with hot water, use alcohol rinse, rinse with water again, air dry, and store in bag." CMA #1 was asked if the nebulizer piece for Resident #9 were stored in a bag. CMA #1 stated, "No." 2. Resident #1 was admitted to the center on 08/13/24 with diagnoses including senile degeneration of the brain, anxiety disorder, gastroesophageal reflux disease, depression, chronic back pain, and edema. A x-ray report, dated 11/18/24, showed Resident #1 received a spine lumbosacral and left foot	C1505		

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C1505	Continued From page 4 x-ray. The x-ray report had a fax received date of 11/18/24 at 1:41 p.m. There was no documentation to show Resident #1's representative was notified of the x-ray results. On 03/04/25 at 12:15 p.m. the DON was asked what the policy was for updating resident representatives of x-ray report results. The DON stated there was not one, but they notify the representative as soon as they got them. The administrator stated they did notify Resident #1's representative verbally of x-ray results as soon as they were received.	C1505		
C1507 SS=D	310:663-15-1 & 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation 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)(7) (7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered;	C1507		

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C1507	Continued From page 5	C1507		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the center failed to ensure there was adequate staff to accommodate safe transfers for 1 (#4) of 9 sampled residents reviewed for safe transferring needs.

The administrator identified 32 residents resided in the center.

Findings:

Resident #4 was admitted to the center on 01/03/25 with diagnoses which included arthritis, chronic pain, thyroid disorder, hypertension, insomnia, restless leg syndrome, sclerosis, and had a history of bilateral knee replacement and spinal fusion.

Resident #4's 14-day comprehensive assessment, dated 01/03/25, documented resident is weight bearing "for a very short time", does not ambulate, and requires "2-3" persons for transferring assistance.

Resident #4's service plan, modification date 01/07/25, showed a non-injury fall on 01/05/25 with an intervention to "Ensure at least three staff members assist with the transfer from bed to wheelchair and gait belt implemented."

The center's staffing schedule documented two staff members were scheduled and worked the 11:00 p.m. to 7 a.m. shifts for the weeks of

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C1507	Continued From page 6 02/23/25 - 03/01/25 and 03/02/25 - 03/06/25. On 03/03/25 at 2:26 p.m., Resident #4 stated they required the assistance of two to three people for transferring, "Especially to and from the toilet." They stated they always had at least two staff members because, "They can't do it with less than that." Resident #4 stated they did have a fall on 01/03/25 and two staff members were assisting them at that time. On 03/04/25 at 11:36 a.m., CMA #2 stated Resident #4 could not bear weight well. CMA #2 stated, "The resident is very hard to transfer with two of us." On 03/04/25 at 12:45 p.m., the DON was asked why there was only two care staff on the overnight shift if Resident #4's service plan had a documented intervention of ensuring three staff members assist with transfer. The DON stated, "I ask for another person and [name withheld] say no because our level of care isn't high enough." The DON was asked if the resident's service plan was being followed and they stated, "No."	C1507		

OKLAHOMA
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Delivery via email to: dajohnson@ireg.us

April 3, 2025

License Number: AL5595

Ms. Danna Johnson, Administrator
Town Village Assisted Living
13000 North May Avenue
Nichols Hills, OK 73120

RE: Survey Event L4KN11

Dear Ms. Johnson:

On **March 7, 2025**, a Licensure inspection with complaint investigation was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 9, 2025**.

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

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

Enclosure

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Donna Johnson TITLE Executive Director (X6) DATE 04/11/25

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 3/25/2025
	Facility Name: Town Village Assisted Living
	License Number: AL5595-5595
	Survey Event ID: OK00078452
	Date Survey Completed: 3/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: observation and interview, the center failed to maintain a clean and sanitary kitchen.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan Of Correction is submitted to meet the requirements established by State and Federal law Assited living will implement plan to ensure deficient practice sited is corrected for unsanitary kitchen.

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?	Kitchen was thouroughly cleaned & sanitized in areas of deficient practice, staff educated & re-trained on their roles in mainting clean kitchen areas for all residents that could be affected. Cleaning schedules updated & re-implimented.
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 assited living residents who are provided a meal from kitchen have potiential to be affected by deficient practice.
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?	Kitchen staff educated on proper cleaning practices, gloves, trash & rags to be kept off floor, work station areas to be kept clean & free from debris, dish pit cleaniness, culinary manager to ensure cleaning practices are followed on a daily basis.
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.	Kitchen staff educated on cleaning tasks & daily assignements, dish pit area cleaning, rag-gloves not to be on floor to ensure kitchen is sanitary Kitchen staff educated on cleaning tasks & daily assignements, dish pit area cleaning, rag-gloves not to be on floor to ensure kitchen is sanitary All results was taken to quarterly QUAPI meetings to include sanitation as focus area. Dietician notified of results Random audit inspections to ensure compliance with sanitation standards to be done by Executive director or regional /local culinary manager or designee 3x weekly for 4 weeks, then monthly x3 months.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/9/2025

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Danna Johnson OAC 310:663-25-4(F)			**Date 4/1/2025**
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.			

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	AL5595	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWN VILLAGE ASSISTED LIVING	13000 NORTH MAY AVENUE NICHOLS HILLS, OK 73120

(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 2 resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to: a. store nebulizer equipment according to standards of practice for 1 (#9) of 4 sampled residents who received breathing treatments; and b. notify a resident's representative of radiological results in a timely manner for 1 (#1) of 9 sampled residents charts reviewed for representative notifications. The administrator identified 32 residents resided in the center.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5595	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWN VILLAGE ASSISTED LIVING	13000 NORTH MAY AVENUE NICHOLS HILLS, OK 73120

(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 3 Findings: 1. On 03/06/25 at 12:22 p.m. Resident #9's nebulizer mouth pieces were observed lying on a paper towel next to the kitchenette sink in the resident's apartment. No storage bag or box was observed. Resident #9 had diagnoses which included dementia, pulmonary fibrosis, diabetes mellitus type 2, neuropathy, benign prostate hypertrophy, essential hypertension, osteoarthritis, senile degeneration of the brain, and gastroesophageal reflux disease. Resident #9's medication list, dated 08/06/24, showed the resident was to receive albuterol sulfate 1.25 milligram/3 milliliter, "inhale 3 ml(s) via nebulizer twice daily." The electronic medication administration record for the resident showed the resident received their breathing treatments at 8:00 a.m. and 8:00 p.m. On 03/06/25 at 2:10 p.m., CMA #1 was asked what were the proper cleaning and storage of nebulizer pieces. CMA #1 stated, "Rinse with hot water, use alcohol rinse, rinse with water again, air dry, and store in bag." CMA #1 was asked if the nebulizer piece for Resident #9 were stored in a bag. CMA #1 stated, "No." 2. Resident #1 was admitted to the center on 08/13/24 with diagnoses including senile degeneration of the brain, anxiety disorder, gastroesophageal reflux disease, depression, chronic back pain, and edema. A x-ray report, dated 11/18/24, showed Resident #1 received a spine lumbosacral and left foot	C1505		

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 3/25/2025
	Facility Name: Town Village Assisted Living
	License Number: AL5595-5595
	Survey Event ID: OK00078452
	Date Survey Completed: 3/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505 Resident Rights—Medical Care	Based on: Observation, record review, interviews the facility failed A) store nebulizer equipment according to standards of practice for 1 of 9 sampled residents (Resident #9) B) notify residents representative in a timely manner of xray results for 1 of 9 sampled residents (resident #1)

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan Of Correction is submitted to meet the requirements established by State and Federal law Assited living will implement plan to ensure deficient practice is corrected for resident rights—medical care

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?	Nebulizer equipment for resident #9 to be cleaned per policy, then placed in storage bags and/or containers, This will be put in place for all residents who have nebulizer treatments. Resident #1 will have radiology results of resident represnetive notified in a timely manner & charted. Flagging system will be done for test results with nurse until results received, all parties notifed and charted. Pending xray results will be audited to ensure notification has happened and charted. All nursing staff educated on new processes for cleaning-storage of nebulizers and notficatiosn of test results.
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 with potiential to be affect who have nebulizer treatments will be audited to ensure they have proper storage bags-containers put in place. Resident with radiology results pending will be identified with physican orders for the test pending to ensure all parties have been notified.
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 residents with nebulizers; will be cleaned as per protocol then to be placed in storage bag or container for proper storage of treatment items. All radiology results, will be flagged with nurse until all results are in, all parties notifed, and charted.

	Nursing staff educated on standard protocol for nebulizer equipment and for timely notification and charting of radiology results notifications.
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.	Enter methods to ensure corrections are sustained: Random audits for properly stored nebulizer treamtments will be done 3x weekly then monthly x3 months by nurse or designee. Any pending test results will be brought up in stand up meetings with audits to be done by ED/DON or designee to ensure charting of notification timely has taken place. Random audits on tests results will be done 3x weekly for 1month then monthly x3months. Results will be taken to QUAPI meeting. Results of audit will be taken to quarterly QUAPI for review. Random audits results will be kept with QUAPI state survey POC book.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Danna Johnson** Danna Johnson OAC 310:663-25-4(F)	**Date 4/1/2025**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5595	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWN VILLAGE ASSISTED LIVING	13000 NORTH MAY AVENUE NICHOLS HILLS, OK 73120

(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 4 x-ray. The x-ray report had a fax received date of 11/18/24 at 1:41 p.m. There was no documentation to show Resident #1's representative was notified of the x-ray results. On 03/04/25 at 12:15 p.m. the DON was asked what the policy was for updating resident representatives of x-ray report results. The DON stated there was not one, but they notify the representative as soon as they got them. The administrator stated they did notify Resident #1's representative verbally of x-ray results as soon as they were received.	C1505		
C1507 SS=D	310:663-15-1 & 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation 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)(7) (7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered;	C1507	SEE ATTACHED POC TEMPLATES	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5595	A. BUILDING: _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWN VILLAGE ASSISTED LIVING	13000 NORTH MAY AVENUE NICHOLS HILLS, OK 73120

(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
C1507	Continued From page 5	C1507		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the center failed to ensure there was adequate staff to accommodate safe transfers for 1 (#4) of 9 sampled residents reviewed for safe transferring needs.

The administrator identified 32 residents resided in the center.

Findings:

Resident #4 was admitted to the center on 01/03/25 with diagnoses which included arthritis, chronic pain, thyroid disorder, hypertension, insomnia, restless leg syndrome, sclerosis, and had a history of bilateral knee replacement and spinal fusion.

Resident #4's 14-day comprehensive assessment, dated 01/03/25, documented resident is weight bearing "for a very short time", does not ambulate, and requires "2-3" persons for transferring assistance.

Resident #4's service plan, modification date 01/07/25, showed a non-injury fall on 01/05/25 with an intervention to "Ensure at least three staff members assist with the transfer from bed to wheelchair and gait belt implemented."

The center's staffing schedule documented two staff members were scheduled and worked the 11:00 p.m. to 7 a.m. shifts for the weeks of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWN VILLAGE ASSISTED LIVING	13000 NORTH MAY AVENUE NICHOLS HILLS, OK 73120

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C1507	Continued From page 6 02/23/25 - 03/01/25 and 03/02/25 - 03/06/25. On 03/03/25 at 2:26 p.m., Resident #4 stated they required the assistance of two to three people for transferring, "Especially to and from the toilet." They stated they always had at least two staff members because, "They can't do it with less than that." Resident #4 stated they did have a fall on 01/03/25 and two staff members were assisting them at that time. On 03/04/25 at 11:36 a.m., CMA #2 stated Resident #4 could not bear weight well. CMA #2 stated, "The resident is very hard to transfer with two of us." On 03/04/25 at 12:45 p.m., the DON was asked why there was only two care staff on the overnight shift if Resident #4's service plan had a documented intervention of ensuring three staff members assist with transfer. The DON stated, "I ask for another person and [name withheld] say no because our level of care isn't high enough." The DON was asked if the resident's service plan was being followed and they stated, "No."	C1507		

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 3/25/2025
	Facility Name: Town Village Assisted Living
	License Number: AL5595-5595
	Survey Event ID: OK00078452
	Date Survey Completed: 3/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1507	Based on: record review and interview the center failed to ensure there was adequate staff on night shift to accomidate a safe transfer for 1 of 9 residents (resident #4)

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan Of Correction is submitted to meet the requirements established by State and Federal law. Assited living will implement plan to ensure deficient practice is corrected for resident rights—reasonable accommodations

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #4 is working with therapy on transfers & has been able to transfer & ambulate short distances only with 1 therapy staff assist. Sit to stand lift and/or transfer chair put in place with accomidation for safe transfers with 2 persons when resident unable to stand. Care plan updated to reflect 2 person transfer for safety with lift or transfer chair when unable to bear weight to stand & do 2 person standing transfer with staff.
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 potiental other affected residents who need assist to transfer will be reviewed by nurse to ensure safety of transfers with no more than 1-2 assist is needed and care planned updated as needed.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Staff educated to report to nurse any issues of resident in transfers. Nurse or therapy will check for any changes in transfers.
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.	Sit to stand lift and/or transfer chair implemented for safety that can be used with 2 person assist. Staff educated on new process. Nurse or designee with do random audits to ensure compliance with trasfers for safety. 3x weekly x 4weeks then monthly x3 months. Audit results of resident transfer care plan reviews will be done in quarterly QUAPI meeting. Random audits by nurse or designee on for transfers on potiental affected residents will be done wwekly for 4

	weeks then monthly x3 months, results will be taken to QUAPI meetings quartley.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Danna Johnson** Danna Johnson OAC 310:663-25-4(F)	**Date 4/1/2025**

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

Delivery via email to: dajohnson@ireg.us

April 14, 2025

License Number: AL5595

Ms. Danna Johnson, Administrator
Town Village Assisted Living
13000 North May Avenue
Nichols Hills, OK 73120

RE: Survey Event L4KN12

Dear Ms. Johnson:

On **April 14, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey with complaints on **March 7, 2025,** have now been corrected effective **April 9, 2025.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5595	A. BUILDING: _____ B. WING _____	R-C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWN VILLAGE ASSISTED LIVING	13000 NORTH MAY AVENUE NICHOLS HILLS, OK 73120

(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 An offsite/paper revisit was conducted on 04/14/25. The facility was in substantial compliance.	{C 000}		

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