OKLAHOMA
State Department
of Health

Delivery via email to: dajohnson@ireg.us

June 2, 2026

License Number: AL5595

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

RE: Survey Event ID: TO4N11

Dear Ms. Johnson:

On **May 6, 2026**, agents from our office concluded a State Licensure survey with complaints 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 **May 6, 2026**.

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 OSDH.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: Town Village Assisted Living
Address: 13000 North May Avenue
City, State, Zip: Nichols Hills, OK., 73120
Provider #: AL5595
Complaint #: OK00087443
Investigation Date(s): 05/04/26-05/06/26

ALLEGATION(S)
The facility failed to ensure residents were not above the level of care for admission/did not exceed discharge criteria.
The facility failed to ensure adequate staff to provide resident care.

An unannounced on-site investigation was initiated 05/04/2026 at 9:00 a.m.

A sample of 7 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 throughout the survey. Residents were observed during meals, in their rooms, in common areas, during medication pass, during transfers and receiving assistance with activities of daily living.

Sampled clinical records, including named residents, were reviewed for physician orders, care plans, progress notes, assessments and discharge criteria. Incident reports, complaint reports along with allegations of neglect were reviewed. Facility policies and procedures were reviewed. Employee regulations and compliance records were reviewed.

Residents were interviewed regarding quality of care, feeling safe in the facility, and receiving assistance in a timely manner. Resident representatives were contacted concerning care for the residents. Staff were interviewed about staffing, providing adequate care for residents, preventing and reporting abuse and neglect.

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: 05/07/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Town Village Assisted Living
Address: 13000 North May Avenue
City, State, Zip: Nichols Hills, OK., 73120
Provider #: AL5595
Complaint #: OK00088129
Investigation Date(s): 05/04/26-05/06/26

ALLEGATION(S)
The facility failed to ensure care was provided for dependent residents.
The facility failed to ensure adequate staff to provide resident care.
The facility failed to ensure the residents did not exceed their discharge criteria

An unannounced on-site investigation was initiated 05/04/2026 at 9:00 a.m.

A sample of 7 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 throughout the survey. Residents were observed during meals, in their rooms, in common areas, during medication pass, during transfers and receiving assistance with activities of daily living and care services.

Sampled clinical records, including named residents, were reviewed for physician orders, care plans, progress notes, assessments, discharge criteria and care for dependent residents. Incident reports, complaint reports along with allegations of neglect were reviewed. Facility policies and procedures were reviewed. Employee regulations and compliance records were reviewed.

Residents were interviewed regarding quality of care, feeling safe in the facility, and receiving assistance in a timely manner. Resident representatives were contacted concerning quality of care for the named residents. Staff were interviewed about staffing, providing adequate care for residents, preventing and reporting abuse and neglect.

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

OKLAHOMA
State Department
of Health

Date report completed: 05/07/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Town Village Assisted Living
Address: 13000 North May Avenue
City, State, Zip: Nichols Hills, OK., 73120
Provider #: AL5595
Complaint#: OK00090782
Investigation Date(s): 05/04/26-05/06/26

ALLEGATION(S)
The facility failed to residents did not have suspicious injuries of unknown origin.

An unannounced on-site investigation was initiated on 05/04/2026 at 9:00 a.m.

A sample of 7 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 throughout the survey. Residents were observed during meals, in their rooms, in common areas, during medication pass, during transfers and receiving assistance with activities of daily living. Upon further investigation, the resident noted on the complaint was found to reside as an independent resident. No further investigation was conducted due to this status.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

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: 05/07/2025

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 _____	C 05/06/2026

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 A relicensure survey with complaints (#OK00087443, OK00088129, and #OK00090782) was conducted from 05/04/26 through 05/06/26. Deficiencies were cited. Facility Census: 26	C 000		
C 391 SS=D	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 facility failed to ensure: a. refrigerated foods removed from original containers were labeled and dated in 1 (main refrigerator) of 2 refrigerators observed in the kitchen, and b. dietary staff covered facial hair while working in food preparation areas for 1 (Cook #2) of 3 staff observed in the kitchen. The administrator identified 26 residents received meals prepared in the facility kitchen. Findings: On 05/04/26 at 9:10 a.m., observations were made of 15 slices of cake, placed in bowels and covered with plastic wrap, five slices of tomatoes in a flat glass plate covered with plastic wrap, one bread pudding in a glass container covered with	C 391		

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 05/06/2026

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 391	Continued From page 1 plastic wrap, and 10 salads in glass bowels covered in plastic wrap. They were stored in the main refrigerator without labels or dates. On 05/04/26 at 9:12 a.m., Cook #1 stated foods removed from original containers were required to be labeled and dated. On 05/05/26 at 7:50 a.m., Cook #2 was observed to work in the kitchen with exposed facial hair and without a beard net. On 05/05/26 at 7:52 a.m., the culinary director stated dietary staff were required to wear beard net while working in food preparation areas. On 05/05/26 at 8:30 a.m., the administrator stated dietary staff were expected to label and date refrigerated foods removed from original containers and wear beard nets while they worked in the kitchen.	C 391		

OKLAHOMA
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Delivery via email to: dajohnson@ireg.us

June 5, 2026

License Number: AL5595

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

RE: Survey Event TO4N11

Dear Ms. Johnson:

On **May 6, 2026**, a Licensure inspection with complaints 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 **June 1, 2026**.

We will conduct a revisit for 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

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 5/10/2013
	Facility Name: Town Village
	License Number: AL5595-5595
	Survey Event ID: TO4N11
	Date Survey Completed: 5/5/2026

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C0391	Based on: Observation-- The center failed to maintain label & dating of food in reach in cooler and failed to maintain beard guard on face of employee with facial hair.

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 Assisted living will implement plan to ensure deficient practice sited is corrected for food not label & dated & beard guards.

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 staff in non-compliance went ahead and placed beard guard on face. Non- compliance with some food items not label & dated in reach in cooler were all dated. All staff educated to be clean shaven or beard guard must be in place, hair nets on for all food prep in kitchen areas. Educated that all food must be label & dated in coolers.
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 assisted living residents who are provided a meal from kitchen have potential 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?	All staff were all educated about survey results including to be clean shaven or beard guard must be in place, hair nets on for all food prep in kitchen areas. Educated that all food must be label & dated in coolers. Director of dining services to ensure these practices are in place.
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.	All staff were all educated about survey results including beard guards/hair nets & label/dating practices. Director of Dining Services to ensure these practices are in place. Audits on survey tagged items to ensure compliance. All items taken to QUAPI meeting to include beard guards & hair nets & label/dating foods as focus areas in kitchen. Random audits to be done by Executive director or Director of Dining services 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?	6/1/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Danna Johnson OAC 310:663-25-4(F)			**Date 6/5/2026**
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.			