OKLAHOMA
State Department
of Health

Delivery via email to: westwindnursing@gmail.com; westwindmarlow@gmail.com

June 8, 2022

License Number: AL6904

Ms. Robbi Matthews, Administrator
West Wind Assisted Living
111 North 9th Street
Marlow, OK 73055

Survey Event ID: BVWC11

Dear Ms. Matthews:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **May 25, 2022**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.06.08 13:15:27 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: West Wind Assisted Living
Address: 111 North 9th Street
City, State, Zip: Marlow, Ok, 73055
Provider #: AL6904
Complaint #: OK00058409
Investigation Date(s): 05/24/22 through 05/25/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure medications were properly administered	US

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

An unannounced on-site investigation was initiated on Tuesday, May 24, 2022 at 8:30 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

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

An investigation specific to ensuring medications were properly administered was conducted.

Sampled clinical records were reviewed for physician orders, service agreements, medication administration records and assessments. Resident council minutes were reviewed and documented no complaints or concerns related to medication administration. Incident reports and employee education forms were reviewed. Facility policies and procedures related to administration of medications were reviewed.

Residents were observed during medication administration. The medication carts were observed to be monitored and appropriately maintained, as well as locked when not in use. The medication storage room was

clean and all medications were observed to be stored properly. Resident bedside tables and nightstands were observed to be free of medications.

Residents, including sampled residents, reported no complaints or concerns related to medications. Residents reported they received their medications as ordered and in a timely manner. One resident reported her medications were left at her bedside one time, but that was taken care of. Staff members reported medications were administered as ordered. Staff reported in February one of the medication aides had left medication in a resident room, the resident reported it, the staff was educated and given a written warning and it has not happened again since then. One sampled resident reported she keeps her medication in her room and self-medicates. She reported the facility keeps her narcotics.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

Donna Ahlborn RN MSN CHFS

Donna Ahlborn RN MSN Clinical Health Facility Surveyor

Date report completed: 05/26/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **West Wind Assisted Living**
Address: **111 North 9th Street**
City, State, Zip: **Marlow Ok, 73055**
Provider #: **AL6904**
Complaint #: **OK00058798**
Investigation Date(s): **05/24/22 and 05/25/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide an environment with comfortable sound levels.	**US**
2. The center failed to follow infection control policies and procedures.	**US**
3. The center failed to provide care and services per physician's orders and plan of care.	**US**
4. The center failed to ensure meals were served in a timely manner.	**US**
5. The center failed to ensure residents' food preferences were honored.	**US**
6. The center failed to accommodate residents' needs.	**US**

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

An unannounced on-site investigation was initiated on Tuesday, May 24, 2022 at 8:30 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

.

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

An investigation specific to comfortable sound levels was conducted.

Sampled clinical records were reviewed for physician orders, service plans, assessments, medication administration records, and policy and procedures. Resident council minutes were reviewed and documented no concerns related to uncomfortable sound levels or barking dogs. Incident reports were reviewed.

A tour of the center was conducted upon entrance and throughout the survey. Sound levels were comfortable in the dining area and throughout the center. No animals were observed in the dining room during the breakfast or lunch meal. One little dog was observed with a resident during an activity. The dog was not heard barking.

Numerous residents, including sampled residents, were interviewed and reported no concerns or complaints related to barking dogs or uncomfortable sound levels. One resident reported the little dog was well mannered. One resident reported I haven't seen any of the bigger dogs that used to be here. Staff reported the residents know they are not allowed to have their pets in the dining room during meal times. Staff reported they previously had an employee who had brought a dog to work, but she no longer works at the center.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to following infection control policies and procedures was conducted.

Sampled clinical records were reviewed for physician orders, service plans, assessments, medication administration records, and policy and procedures. Resident council minutes were reviewed and documented no concerns related to infection control issues. Infection control policies and procedures were reviewed. Incident reports were reviewed.

Observations were made of breakfast and lunch being served, and lunch being prepared, no infection control issues were observed. None of the residents were observed preparing food. Staff were observed washing their hands before and during meals.

Residents reported they are allowed to prepare snacks for their family for planned parties. They reported those snacks are not served to all of the residents in the center. Staff reported the kitchen staff help the residents when preparing snacks for their individual family events. Staff reported a resident had recently made a meat platter for her family. Staff reported they follow infection control policy and procedures.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to providing care according to physician orders and plan of care was conducted.

Sampled clinical records were reviewed for physician orders, service agreements, assessments, care plan, and progress notes. Resident council minutes and grievance logs were reviewed and documented no concerns related to residents not receiving care according to physician orders or care plan. The sampled resident's activities of daily living care records were reviewed and documented showers/baths had been received unless they refused. Incident reports were reviewed.

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed to be clean and well-groomed. None of the residents had any offensive body odors.

Numerous residents, including sampled residents, were interviewed and reported no concerns or complaints of not receiving their showers. One sampled resident reported if staff comes before breakfast or after supper I'll let them help me clean up otherwise I do it myself or refuse. She/he reported any extra ADL care cost more money.

Allegation #4: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to meals being served in a timely manner was conducted.

Dietary records were reviewed. Meal time policies and procedures were reviewed. Resident counsel minutes and incident reports were reviewed and documented no complaints or issues related to meals not served in a timely manner.

Observations were made of the residents being served for breakfast and lunch. Breakfast was served between 6:30 a.m. and 10 a.m. and lunch was served between 11:30 a.m. and 1:00 p.m. The residents could come to the dining room anytime between those hours and receive food. There was a nutrition center in the dining area where food was available 24 hours a day which included snack food, beverages and fresh fruit.

Residents were interviewed and reported they get plenty of food and then some. Residents reported they can get food anytime they want. One resident reported if they bring the food to your room it's an extra charge so I go to the dining room. Staff reported the meals are always on time and they can even get breakfast all day long if they want it. One resident reported once they brought the wrong food to my room, but it hasn't happened again. Residents reported they could order an alternate meal if they didn't like what was being served. Staff reported a knowledge of residents with dietary restrictions. Kitchen staff reported they tried to offer a variety of choices while following approved menus.

Allegation #5: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to food preference was conducted.

See Allegation #4

Allegation #6: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to accommodating residents' needs was conducted.

The facility service agreement was reviewed. Resident council minutes were reviewed and documented no concerns related to laundry services. Incident reports were reviewed and documented no issues related to laundry or personal belongings.

Residents were observed upon entrance and throughout the investigation. Resident rooms were observed to contain resident belongings in a homelike environment. Residents were observed to be neat, clean, and well-groomed. Residents were observed to be dressed in appropriate clothes of their choice. The laundry service area was toured and found to be clean, with clothing separated by resident names.

Numerous residents reported they take care of their own laundry or their family does it for them. Some residents reported their clothes are picked up twice a week by the center laundry staff and then returned either the next day or the day after that. One sampled resident reported once it took her two days to get her clothes back from the laundry. One staff reported she washes the residents' sheets and blankets and returns them the same day she washes them. Staff reported the residents usually receive their clothing back the next day.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1, 2, 3, 4, 5, and #6. No further action is required.

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

Thank you for bringing these concerns to our attention.

Donna Ahlborn RN MSN CHFS

Donna Ahlborn RN MSN Clinical Health Facility Surveyor

Date report completed: 05/26/2022

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
	AL6904	A. BUILDING: _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND ASSISTED LIVING	111 NORTH 9TH STREET MARLOW, OK 73055

(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 (#OK00058798 and #OK00058409) were conducted from 05/24/22 through 05/25/22. No deficiencies were cited.	C 000		

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