OKLAHOMA
State Department
of Health

Delivery via email to: wwalcoffice@gmail.com

June 13, 2023

License Number: AL6904

Mr. Jeff Gregston, Administrator
West Wind Assisted Living
111 North 9th Street
Marlow, OK 73055

RE: Survey Event ID: WHJ011

Dear Mr. Gregston:

On **May 10, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on May 10, 2023.

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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. 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 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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 or conducted in a face-to-face 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.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

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 _____	05/10/2023

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 A relicensure survey was conducted from 05/09/23 through 05/10/23. The following are abbreviations which may be used in this document: DON - Director of Nursing MAT - Medication Aide Tech MG - Milligram RES - Resident RN - Registered Nurse	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed at least every 12 months for one (#1) of eight residents reviewed for compliance with required comprehensive assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 05/09/23, documented 42 residents resided in the facility. Findings:	C 522		

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C 522	Continued From page 1 The facility did not provide a policy regarding comprehensive resident assessments. Resident #1 was admitted to the facility on 01/29/22. The resident's clinical record documented the last comprehensive resident assessment was completed on 02/11/22. There was no documentation of a comprehensive resident assessment for time period, 03/2023, 04/2023 or 05/01-05/10/23. On 05/10/22 at 3:00 p.m., the DON reviewed the resident's chart and reported the resident had not had an annual comprehensive resident assessment completed. The DON reported the comprehensive resident assessments were required to be conducted annually by the registered nurse.	C 522		
C 921 SS=E	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 facility	C 921		

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C 921	Continued From page 2 failed to ensure monthly medication reviews were conducted by a registered nurse or pharmacist for three (#1, 3, and #7) of three residents reviewed for medications. The "Assisted Living Resident Condition and Care Overview" report, dated 05/09/23, documented 42 residents resided in the facility. Findings: The facility did not provide a policy regarding monthly medication review. 1. Resident #1 was admitted to the facility on 01/29/22. Res #1's "Physician Orders," dated 03/01/23, 04/01/23, and 05/01/23, documented a signature of review by a licensed practical nurse. 2. Resident #3 was admitted to the facility on 09/09/21. Res #3's "Physician Orders," dated 03/01/23, 04/01/23, and 05/01/23, documented a signature of review by a licensed practical nurse. 3. Resident #7 was admitted to the facility on 05/16/22. Res #7's "Physician Orders," dated 03/01/23, 04/01/23, and 05/01/23, documented a signature of review by a licensed practical nurse. On 05/10/23 at 3:07 p.m., the DON reported being a licensed practical nurse and stated she was responsible for doing the monthly medication reviews. The DON reported medications were not reviewed monthly by an RN or a pharmacist. The	C 921		

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C 921	Continued From page 3 DON reported she was not aware monthly medication reviews were to be conducted by an RN or pharmacist.	C 921		
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 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.	C1505		

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C1505	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to perform appropriate hand hygiene during medication administration for five (#9, 10, 11, 2, and #12) of 11 residents observed during the medication administration pass. The "Assisted Living Resident Condition and Care Overview" report, dated 05/09/23, documented 42 residents resided in the facility. Findings: The facility's "Steps in Medication Administration" policy, not dated, read in part, "...Bring the medication cart to the vicinity of the resident's apartment...Wash hands using appropriate hand washing technique...Prepare medication for administration..." On 05/09/23 at 11:37 a.m., a medication pass observation was initiated with MAT #1. The MAT was observed to prepare Resident #9's medication for administration. MAT #1 punched out an oxybutynin 5 mg tablet from a blister pack into their hand and then placed the tablet into a paper souffle cup. MAT #1 delivered the medication to the resident and returned to the medication cart. MAT #1 began preparing the next resident's medication without performing hand hygiene. On 05/09/23 at 11:40 a.m., MAT #1 was observed	C1505		

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C1505	Continued From page 5	C1505		

to prepare Resident #10's medication for administration. MAT #1 was observed touching their hair, using a laptop computer, and handling keys to the medication cart. MAT #1 punched out a hydralazine 25 mg pill into their hand from a blister pack and then placed the tablet into a paper souffle cup. MAT #1 delivered the medication to the resident and returned to the medication cart. MAT #1 did not perform hand hygiene before, during, or after the medication administration.

On 05/09/23 at 11:43 a.m., MAT #1 was observed to prepare Resident #11's medication for administration. MAT #1 was observed touching their hair, using the laptop, and handling the medication cart keys. MAT #1 punched out a Mobic 15 mg pill into their hand from a blister pack and then placed the tablet into a paper souffle cup. MAT #1 delivered the medication to the resident and returned to the medication cart. MAT #1 did not perform hand hygiene before, during, or after the medication administration.

On 05/09/23 at 11:46 a.m., MAT #1 was observed to prepare Resident #2's medication for administration. MAT #1 was observed touching their hair, using the laptop, and handling the medication cart keys. MAT #1 punched out a carbidopa/levodopa 25-100 mg pill from a blister pack into a paper souffle cup. MAT #1 delivered the medication to Resident #2, had to touch the resident to wake her, and then returned to the medication cart. MAT #1 did not perform hand hygiene before, during, or after the medication administration.

On 05/09/23 at 11:55 a.m., MAT #1 was observed to prepare Resident #12's medication for administration. MAT #1 was observed using the

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C1505	Continued From page 6 laptop and handling the medication cart keys during medication preparation. MAT #1 placed an aspirin 81 mg tablet and magnesium oxide 500 mg tablet from the bottle into their hand, then into a paper souffle cup. MAT #1 delivered the medication to Resident #12. MAT #1 did not perform hand hygiene before, during, or after the medication administration. On 05/09/23 at 12:05 p.m., MAT #1 was questioned regarding the medication pass. MAT #1 reported they should not have placed the medications into her hand before placing into the souffle cup. MAT #1 was asked about hand hygiene and reported they were not allowed to keep hand gel on the medication cart. MAT #1 reported they typically perform hand hygiene in the resident rooms but failed to do so during this medication pass. On 05/10/23 at 1:30 p.m., the DON reported staff should perform hand hygiene between each resident, and hand gel was allowed on the medication cart for staff use.	C1505		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act.	C5010		

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C5010	Continued From page 7 C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to monitor services and coordinate care provided by hospice for two (#1 and #3) of two residents reviewed for hospice services. The "Assisted Living Resident Condition and Care Overview," dated 05/09/23, documented seven residents received hospice care. Findings: The "Coordination/Individualization of Services" policy, not dated, read in part, "...To assure continuity of services to each resident...To assure individualization of services to each resident, thus	C5010		

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C5010	Continued From page 8	C5010		

decreasing the feeling of an institutional environment...Staff will be familiar with each resident's needs and overall situation..."

1. Resident #1 had diagnoses which included Parkinson's disease, dysphagia, hypertension, and diabetes mellitus.

A "Hospice Certification and Plan of Care" for Resident #1, dated 08/23/22, documented a certification period of 08/23/22 to 11/20/22. There was no documentation to show the resident was continuing to receive hospice services from 11/21/22 through 05/10/23.

On 05/09/23 at 11:46 a.m., Resident #1 was observed in their room, sleeping in the recliner. MAT #1 was attempting to awaken Resident #1 to administer a scheduled medication. The resident was lethargic and hard to arouse. MAT #1 was able to awaken the resident enough to allow her to swallow the scheduled medication. The MAT left the resident's room and reported the behavior to the DON.

On 05/10/23 at 11:00 a.m., the DON reported Resident #1 had been assessed by the hospice nurse on 05/09/23 when the MAT reported the change in behavior. The DON reported the hospice nurse verbally discussed the resident's condition after the hospice visit. The DON reported it was discussed with the hospice nurse that the resident might need to be admitted to a long term care facility. The DON reported this was not documented in the resident's medical record. The DON was questioned regarding how the facility monitored hospice services, any changes made, and what services were provided. The DON reported a communication form was used to report changes and hospice staff were

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C5010	Continued From page 9 observed in the facility. The DON reported no communication form for Resident #1 was available related to the behavior change on 05/09/23, since it was done verbally. The DON reported the information was not documented in the resident's clinical record. The DON reported no hospice care notes were kept in the facility. The DON reported they had a book with each resident's hospice plan of care but it had not been updated for current certification periods. 2. Resident #3 was readmitted to the facility on 01/10/23 with diagnoses which included malignant neoplasm of colon, intestinal obstruction, chronic obstructive pulmonary disease, colostomy, and arteriosclerotic heart disease. Resident #3's Assisted Living Service Plan," dated 03/21/23, read in part, "...Decline in condition...Needs frequent cleaning of the bathroom done related to resident emptying colostomy...Plan of accommodation in place for hospice...Hospice assists with activities of daily living, showers colostomy bag changes, provides incontinent supplies, and medications...Resident may require a higher care than this facility..." On 05/10/23 at 11:30 a.m., the DON reported no hospice service plan was available for Resident #3 but she would contact hospice to have it faxed to the facility. The DON reported no documentation was available in the resident's clinical record with the start date of hospice services or the services that hospice had provided to the resident. On 05/10/23 at 4:30 p.m., the DON provided Resident #3's "Hospice Plan of Care," dated 04/12/23, which was just received from the	C5010		

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C5010	Continued From page 10 hospice provider via fax on this day. The "Hospice Plan of Care" documented a start of care date as 01/11/23.	C5010		

OKLAHOMA
State Department
of Health

Delivery via email to: wwalcoffice@gmail.com;

June 27, 2023

License Number: AL6904

Mr. Jeff Gregston, Administrator
West Wind Assisted Living
111 North 9th Street
Marlow, OK 73055

RE: Survey Event WHJ011

Dear Mr. Gregston:

On **May 10, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your 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 **July 15, 2023**.

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,

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/18/2023** **Facility Name:** West Wind Assisted Living **License Number:** AL6904 **Survey Event ID:** WHJ011 **Date Survey Completed: 5/10/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522	Based on: record review and interview, the facility failed to ensure a comprehensive assessment was completed at least every 12 months for one of eight residents reviewed for compliance with required comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The administrative staff have a shared calendar on Google Teams where we keep appointment schedules for residents for doctor's visits and other important dates. We will begin adding deadline dates for assessments onto this private calendar to remind the appropriate staff when these assessments are due, as we access this calendar on a daily basis and will regularly see any upcoming due dates.
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 had a chart review completed by administrative staff and no other residents were impacted by this 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?	The administrative staff have a shared calendar on Google Teams where we keep appointment schedules for residents for doctor's visits and other important dates. We will begin adding deadline dates for assessments onto this private calendar to remind the appropriate staff when these assessments are due, as we access this calendar on a daily basis and will regularly see any upcoming due dates.
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.	Administrative staff will review effectiveness at quarterly QA meetings until compliance has been confirmed. Random audits will be preformed by the RN Consultant for compliance and accuracy. RN will report the results of the random audits to the QA Committee. We will continue to put these dates on the administrative calendar upon move-in and put in a yearly reminder. This will be randomly audited by the administrative team and reported at quarterly QA Meetings.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/15/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Jeff L. Gregston, NHA OAC 310:663-25-4(F)			**Date 6/18/2023**
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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/18/2023** **Facility Name:** West Wind Assisted Living **License Number:** AL6904 **Survey Event ID:** WHJ011 **Date Survey Completed: 5/10/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 921	Based on: record review and interview, the facility failed to ensure monthly medication reviews were conducted by a registered nurse or pharmacist for three of three residents reviewed for medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The facility is currently having each resident's physician review their orders monthly and upon significant change. We will continue to do this, but in the event the resident's orders have not been returned to the facility in a timely manner, we will request an RN or pharmacist review or have our medical director review the resident's orders that have not been returned before the end of each month.
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 had a chart review completed by administrative staff and no other residents were impacted by this 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?	In this situation, the orders had not been faxed back to the facility or picked up from their offices by our staff. We will audit charts for monthly orders and request a review of those not returned by the resident's physician.
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.	Administrative staff will review effectiveness at quarterly QA meetings until compliance has been confirmed. Random audits will be preformed by the RN Consultant for compliance and accuracy. RN will report the results of the random audits to the QA Committee. This will be randomly audited by the administrative team and reported at quarterly QA Meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jeff L. Gregston, NHA** OAC 310:663-25-4(F)	**Date 6/18/2023**

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.

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/18/2023** **Facility Name:** West Wind Assisted Living **License Number:** AL6904 **Survey Event ID:** WHJ011 **Date Survey Completed: 5/10/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: record review and interview, the facility failed to perform appropriate hand hygiene during medication administration for five residents.

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?	Nursing staff will be in-serviced on 7/7/23 on appropriate hand washing for medication administration. All staff will be in-serviced on the same date regarding proper handwashing in all other situations.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON has observed staff on all other shifts to ensure deficient practice is not evident with other staff. No other staff members were found to have not followed proper handwashing policies during medication administration.
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?	DON will randomly audit medication administration each month to ensure deficient practice is not reoccurring and will retrain any staff found to not following proper policies.
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.	Administrative staff will review effectiveness at quarterly QA meetings until compliance has been confirmed. Random audits will be preformed by the RN Consultant for compliance and accuracy. RN will report the results of the random audits to the QA Committee. This will be randomly audited by the administrative team and reported at quarterly QA Meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jeff L. Gregston, NHA** OAC 310:663-25-4(F)	**Date 6/18/2023**

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.

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/18/2023** **Facility Name:** West Wind Assisted Living **License Number:** AL6904 **Survey Event ID:** WHJ011 **Date Survey Completed: 5/10/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1510	Based on: record review and interview, the facility failed to coordinate care provided by hospice for two residents reviewed for hospice services.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All agencies will be contacted before 8/1/2023 to remind them that all care plans must be given to DON at the time of completion. At this time, all care plans are updated for all 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?	DON has performed chart audits to ensure no other residents were impacted by this 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?	DON will randomly audit charts each month to ensure deficient practice is not reoccurring and will issue a written warning for agencies found to not following proper policies.
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.	Administrative staff will review effectiveness at quarterly QA meetings until compliance has been confirmed. Random audits will be preformed by the RN Consultant for compliance and accuracy. RN will report the results of the random audits to the QA Committee. This will be randomly audited by the administrative team and reported at quarterly QA Meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jeff L. Gregston, NHA** OAC 310:663-25-4(F)	**Date 6/18/2023**

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

OKLAHOMA
State Department of Health

Delivery via email to: **w**walcoffice@gmail.com

August 29, 2023

License Number: AL6904

Mr. Jeff Gregston, Administrator
West Wind Assisted Living
111 North 9th Street
Marlow, OK 73055

RE: Survey Event WHJ012

Dear Mr. Gregston:

On **August 27, 2023,** 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 on **May 10, 2023,** have now been corrected effective **July 15, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 _____	R 08/27/2023

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 An offsite/paper revisit was conducted on 08/27/23. 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