OKLAHOMA
State Department
of Health

Delivery via email to: wwalcoffice@gmail.com

April 24, 2024

License Number: AL6904

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

RE: Survey Event ID: HKNC11

Dear Mr. Gregston:

On **April 16, 2024**, 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 no 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 **April 16, 2024**.

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.

OKLAHOMA
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INVESTIGATIVE REPORT

Facility: **West Wind Assisted Living**
Address: **111 North 9th Street**
City, State, Zip: **Marlow, OK, 73055**
Provider #: **AL6904**
Complaint #: **OK00064077**
Investigation Date(s): **04/16/24**

ALLEGATION(S)
The center failed to protect residents from abuse.

An unannounced on-site investigation was initiated 05/16/2023 at 9:20 a.m.

A sample of three 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:

Throughout the survey observations were conducted for resident abuse.

Interviews were conducted with residents and staff regarding abuse, abuse training, and abuse reporting.

Record reviews consisted of resident clinical records, incident reports, and grievance logs.

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: 04/17/2024

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 _____	C 04/16/2024

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 complaint investigation (#OK00064077) was conducted on 04/16/24. Facility Census: 45 Listed below are the abbreviations that will be used throughout this document. AIT - Administrator in Training CMA - Certified Medication Aide DON - Director of Nursing	C 000		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

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	AL6904	A. BUILDING: _____ B. WING _____	C 04/16/2024

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C1911	Continued From page 1	C1911		

This Rule is not met as evidenced by:
Based on record review and interview, the center failed to report an alleged incident of abuse to the Oklahoma State Department of Health within one department business day of the reportable incident for two (#1 and #2) of three sampled residents reviewed for timely incident reporting.

The DON identified 45 Residents resided in the center.

Findings:

A "Reporting Policy" document, undated, read in part,"...All reports to the Department shall be made within twenty-four (24) hours of the reportable incident..."

1. Resident #1 was admitted on 05/01/18 with diagnoses which included anoxic brain damage, dementia, and bipolar disorder.

A "Rolling Hills" psychological assessment, dated 10/21/24, documented resident #1's cognition was moderately impaired.

A "Notes Report" document, dated 04/01/24 through 04/04/24, read in part, "...04/02/2024 at 11:06 pm...[CMA #1] reported that [Resident name withheld] was making allegations about another resident being inappropriate with[them]...stated that the [resident in room number withheld] kept touching [their] breast...and ...kiss...[they] did say no but [they]

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C1911	Continued From page 2 kept pursuing touching..." 2. Resident #2 was admitted on 10/04/23 with diagnoses which included dementia and amnesia. A "Mental Status" document, dated 09/18/23, documented Resident #2's cognition was moderately impaired. A "Notes Report", dated 04/01/24 through 04/02/24, read in part, "...[resident name withheld] was accused of being inappropriate with another resident...[they] were instructed to stay out of [residents room number withheld]..." A "Incident Report Form", dated 04/04/24, documented there was an allegation Resident #2 was suspected of a criminal act towards Resident #1 of inappropriate touching. A "Fax Cover Sheet", dated 04/09/24, documented the facility reported incident was transmitted on 04/11/24 at 11:36 a.m. On 04/16/24 at 1:20 p.m., the DON was asked about the incident between Resident #1 and Resident #2 on 04/02/24. The DON stated that they were made aware of the allegation of inappropriate touching on 04/02/24. The DON stated they made a mistake, did not follow the policy and notified the Oklahoma State Department of Health on 04/11/24 of the alleged incident on 04/02/24. On 04/16/24 at 03:06 p.m., the AIT stated they were informed of the incident on 04/03/24. The AIT stated they did not follow the 24 hour reporting guideline because they were under the impression there was a 10 day period for reporting incidents and was not aware of the 24	C1911		

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C1911	Continued From page 3 hour reporting requirements to Oklahoma State Department of Health.	C1911		

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Delivery via email to: wwalcoffice@gmail.com;

May 7, 2024

License Number: AL6904

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

Survey Event ID: HKNC11

Dear Mr. Gregston:

On **April 16, 2024,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 10, 2024**.

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/1/2024** **Facility Name:** West Wind Assisted Living **License Number:** AL6904 **Survey Event ID:** HKNC11 **Date Survey Completed: 4/16/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C-1911 S/S D	Based on: Based on record review and interview, the centerfailed to report an alleged incident of abuse to theOklahoma State Department of Health within onedepartment business day of the reportableincident for two (#1 and #2) of three sampled residents reviewed for timely incident reporting.

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?	DON has completed the proper incident report and sent to OSDH. The report was completed as a initial and final together on 4/11/2024. The issue was determined that the DON waited to submit a final report with the initial report, making the proper reporting timeline incomplete according to statue.
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 incidents from the past quarter will be randomly audited by RN consultant to ensure proper reporting has been completed and turned into OSDH in a timely manner.
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 will be trained on reporting standards according to facility policy and state statute. All incident reports will be reviewed by RN Consultant, DON, or Admin prior to submission to ensure the proper type of reporting is completed in a timely manner.
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.	Quarterly QA meetings will include a review of reporting timelines to ensure accuracy and proper submissions. This will be monitored and recorded in our quarterly QA records. Staff will be educated regarding incident reporting and timelines on 5/10/2024. Incident reporting records will be reviewed for accuracy each quarter by the QA Team. Incident reporting binder will be brought to QA meeting and reviewed by QA Team
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/10/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jeff L. Gregston**	**Date 5/1/2024**

OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Jeff L. Gregston
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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Delivery via email to: wwalcoffice@gmail.com;

June 10, 2024

License Number: AL6904

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

Survey Event ID: HKNC12

Dear Mr. Gregston:

On **June 7, 2024,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 16, 2024,** have now been corrected effective **May 10, 2024.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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{C 000}	INITIAL COMMENTS A revisit was conducted 06/07/24. All deficiencies from the 04/16/24 survey were cleared.	{C 000}		

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