
Delivery via email to: jeffgregston@gmail.com; wwalcoffice@gmail.com

June 19, 2024

License Number: AL6904

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

RE: Survey Event ID: IVHR11

Dear Mr. Gregston:

On **June 12, 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 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 **June 12, 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.

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: IDRCoordinator@health.ok.gov
or mail 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,

Tempal Killman

Tempal Killman, Enforcement Analyst
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: AL6904	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER WEST WIND ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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
D 000	INITIAL COMMENTS An advantage survey was conducted 06/07/24 and 06/10/24 through 06/12/24. No deficiencies were cited. Resident census was 47.	D 000		
C 000	INITIAL COMMENTS A relicensure survey was conducted 06/07/24 and 06/10/24 through 06/12/24. Resident census was 47.	C 000		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the residents representative and the person completing the form for seven (#1, 2, 3, 4, 6, 7 and #8) of 8 sampled residents reviewed for comprehensive assessments. The Administrator in training identified 47 residents resided at the center.	C 543		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER WEST WIND ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 111 NORTH 9TH STREET MARLOW, OK 73055		
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C 543	Continued From page 1 Findings: Resident #1's comprehensive assessment, dated 03/22/24, was not signed by the resident and/or their representative. Resident #2's comprehensive assessment, dated 03/22/24, was not signed by the resident and/or their representative. Resident #3's comprehensive assessment, dated 05/31/24, was not signed by the resident and/or their representative. Resident #4's comprehensive assessment, dated 06/06/24, was not signed by the resident and/or their representative. Resident #6's comprehensive assessment, dated 12/13/24, was not signed by the resident and/or their representative. Resident #7's comprehensive assessment, dated 12/08/23, was not signed by the resident and/or their representative. Resident #8's comprehensive assessment, dated 07/10/23, was not signed by the resident and/or their representative. On 06/11/24 at 4:02 p.m., the DON stated they did not know the signatures were mandatory.	C 543		

Delivery via email to: wwalcoffice@gmail.com

July 15, 2024

License Number: AL6904

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

RE: Survey Event IVHR11

Dear Ms. Garvin:

On **June 12, 2024**, 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 20, 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: 6/27/2024

Facility Name: West Wind Assisted Living

License Number: AL6904

Survey Event ID: IVHR11

Date Survey Completed: 6/12/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 543

Based on: Center failed to ensure each comprehensive assessment included a personal interview between the resident representative and the person completing the form for seven of eight sampled residents reviewed for 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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All comprehensive assessments will be signed by the resident or their representative, as available.

If a resident cannot sign and a responsible party has not been established or is unavailable in person, Administrator will sign as a witness that the resident and/or responsible was included in the completion of the assessment.

Director of Nursing reviewed each resident's most recent assessment to ensure signatures were received by the resident or responsible party, as available.

If a resident cannot sign and a responsible party has not been established or is unavailable in person, Administrator will sign as a witness that the resident and/or responsible was included in the completion of the assessment.

Director of Nursing will ensure each resident or representative of residents sign the assessment upon completion of the assessment, as available.

If a resident cannot sign and a responsible party has not been established or is unavailable in person, Administrator will sign as a witness that the resident and/or responsible was included in the completion of the assessment.

The QA Committee will review for compliance each quarter until facility reaches consistent compliance.

Enter methods to evaluate for effectiveness:

If a resident cannot sign and a responsible party has not been established or is unavailable in person, Administrator will sign as a witness that the resident and/or responsible was included in the completion of the assessment.

QA Committee representative will randomly select resident charts prior to each QA meeting to ensure signatures have been received.

10012013

correction.		
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		7/20/2024
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Administrator's signature required. OAC 310:663-25-4(F)		Date 6/28/2024
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.		

Delivery via email to: wwalcoffice@gmail.com

August 7, 2024

License Number: AL6904

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

RE: Survey Event IVHR12

Dear Ms. Garvin:

On **August 2, 2024**, an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your Licensure survey on **June, 12, 2024**, have now been corrected effective **July 20, 2024**.

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

Respectfully,

Tempal Killman

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

Enc

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6904	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/02/2024
NAME OF PROVIDER OR SUPPLIER WEST WIND ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{D 000}	INITIAL COMMENTS	{D 000}		
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 08/02/24. 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