Oklahoma State Department of Health
Creating a State of Health

August 27, 2019

License Number: CC1101AL

Ms. Marci Warren, Administrator
Go Ye Village Continuum Of Care Retirement Community
1201 West 4th Street
Tahlequah, OK 74464

**RE: Survey Event ID: 03NZ11**

Dear Ms. Warren:

On August 9, 2019, 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 August 9, 2019.

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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

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 |
|---|---|---|---|
| | CC1101AL | A BUILDING _____ B WING _____ | 08/09/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GO YE VILLAGE CONTINUUM OF CARE RETIR | 1201 WEST 4TH STREET TAHLEQUAH, OK 74464 |

| (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<br><br>A re-licensure survey was conducted on 08/08/19 and 08/09/19. The census was 35. The following deficient practice was cited. | C 000 | | |
| C 329 SS=E | 310:663-3-3(a)(9) DESCRIPTION OF SERVICES<br><br>(a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services:<br><br>(9) provisions for evacuation of the building structure and staff to meet the evacuation needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, it was determined the center failed to describe in the residency agreement the service to be provided or arranged in the assisted living center with respect to the provisions for evacuation of the building structure for 3 (#1, 3, and #5) of 8 sampled residents. This failed practice had the risk for more than minimal harm, at a pattern.<br><br>Findings:<br><br>On 08/09/19 at 12:05 p.m., contracts were reviewed with the assistance of the administrator. She was asked about documentation in the residency agreements, regarding provisions for evacuation, for all sampled residents.<br><br>The administrator stated she could not find anything that stated evacuation in the contract. | C 329 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | CC1101AL | A BUILDING _____ B WING _____ | 08/09/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GO YE VILLAGE CONTINUUM OF CARE RETIR | 1201 WEST 4TH STREET TAHLEQUAH, OK 74464 |

| (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 |
|---|---|---|---|---|
| C1326 SS=D | 310.663-13-2(6) CONTENTS OF CONTRACT<br><br>Each resident service contract shall contain a clear statement of the following:<br>(6) charges for services;<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, it was determined the center failed to ensure resident contracts contained a clear statement of the charges for additional services for 1 (#4) of 8 sampled residents This failed practice had the isolated potential for more than minimal harm.<br>Findings:<br><br>On 08/09/19 at 12:05 p.m., the resident service contracts (aggreements) were reviewed with the administrator. The administrator was asked about the missing charges on the contract for resident #6. She said that page was missing from the residents contract. | C1326 | | |

FORM APPROVED

# *STATE WORKLOAD REPORT*

| Provider/Supplier Number | Provider/Supplier Name |
|---|---|
| CC1101AL | GO YE VILLAGE CONTINUUM OF CARE RETIREMENT COMMUNI |

Type of Survey (select all that apply)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 2 | | | | | | | | |

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| A | | | | | | | | |

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

## SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number

| Surveyor ID Number (A) | First Date Arrived (B) | Last Date Departed (C) | Pre-Survey Preparation Hours (D) | On-Site Hours 12am-8am (E) | On-Site Hours 8am-6pm (F) | On-Site Hours 6pm-12am (G) | Travel Hours (H) | Off-Site Report Preparation Hours (I) |
|---|---|---|---|---|---|---|---|---|
| Team Leader ID | | | | | | | | |
| 1. 32388 | 08/08/2019 | 08/09/2019 | 0.50 | 0.00 | 5.75 | 0.00 | 4.50 | 5.00 |
| 2. 18873 | 08/08/2019 | 08/09/2019 | 0.50 | 0.00 | 5.75 | 0.00 | 4.00 | 1.00 |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |
| 8. | | | | | | | | |
| 9. | | | | | | | | |
| 10. | | | | | | | | |
| 11. | | | | | | | | |
| 12. | | | | | | | | |
| 13. | | | | | | | | |
| 14. | | | | | | | | |

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

AUG 28 2019

Oklahoma State Department of Health
Creating a State of Health

September 10, 2019

License Number:CC1101AL

Ms. Marci Warren, Administrator
Go Ye Village Continuum Of Care Retirement Community
1201 West 4th Street
Tahlequah, OK 74464

**RE: Survey Event 03NZ11**

Dear Ms. Warren:

On August 9, 2019, 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 **October 21, 2019**.

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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/KS

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 |
|---|---|---|---|
| | CC1101AL | A. BUILDING: _____ B. WING _____ | 08/09/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GO YE VILLAGE CONTINUUM OF CARE RETIREMENT | 1201 WEST 4TH STREET TAHLEQUAH, OK 74464 |

| (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<br><br>A re-licensure survey was conducted on 08/08/19 and 08/09/19. The census was 35. The following deficient practice was cited. | C 000 | | |
| C 329 SS=E | 310:663-3-3(a)(9) DESCRIPTION OF SERVICES<br><br>(a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services:<br><br>(9) provisions for evacuation of the building structure and staff to meet the evacuation needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, it was determined the center failed to describe in the residency agreement the service to be provided or arranged in the assisted living center with respect to the provisions for evacuation of the building structure for 3 (#1, 3, and #5) of 8 sampled residents. This failed practice had the risk for more than minimal harm, at a pattern.<br><br>Findings:<br><br>On 08/09/19 at 12:05 p.m., contracts were reviewed with the assistance of the administrator. She was asked about documentation in the residency agreements, regarding provisions for evacuation, for all sampled residents.<br><br>The administrator stated she could not find anything that stated evacuation in the contract. | C 329 | See attached Plan of Correction | 10/21/19 |

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheryl McDonald TITLE: Administrator (X6) DATE: 9-6-2019

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 |
|---|---|---|---|
| | CC1101AL | A. BUILDING: _____ B. WING _____ | 08/09/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GO YE VILLAGE CONTINUUM OF CARE RETIREMENT | 1201 WEST 4TH STREET TAHLEQUAH, OK 74464 |

| (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 |
|---|---|---|---|---|
| C1326 SS=D | 310:663-13-2(6) CONTENTS OF CONTRACT<br><br>Each resident service contract shall contain a clear statement of the following:<br>(6) charges for services;<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, it was determined the center failed to ensure resident contracts contained a clear statement of the charges for additional services for 1 (#4) of 8 sampled residents. This failed practice had the isolated potential for more than minimal harm. Findings:<br><br>On 08/09/19 at 12:05 p m., the resident service contracts (aggreements) were reviewed with the administrator. The administrator was asked about the missing charges on the contract for resident #6. She said that page was missing from the residents contract. | C1326 | See attached Plan of Correction | 10/21/2019 |

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 9/6/2019**<br>**Facility Name:** Go Ye Village Continuum of Care Retirement Community<br>**License Number:** CC1101AL<br>**Survey Event ID:** 03NZ11<br>**Date Survey Completed: 8/9/2019** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 329 | Based on: Based on record review and interview, it was determined the center failed to describe in the residency agreement the service to be provided or arranged in the assisted living center with respect to the provisions for evacuation of the building structure for 3 (#1, 3, and #5) of 8 sampled residents. This failed practice had the risk for more than minimal harm, at a pattern |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction Go Ye Village Continuum of Care Retirement Community does not admit that the deficiencies listed on the HCFA 2567 exists, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts and conclusions that form the basis for each deficiency.

| **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? | Resident's #1, #3 and #5 have been provided an evacuation floor plan. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | Upon admission all residents will receive a verbal explanation of provisions for evacuation and a copy of the evacuation floor plan with the resident service contract. Residents currently residing in the Assisted Living Neighborhood have been provided a verbal explanation of the provisions for evacuation and a copy of the evacuation floor plan. |
| 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 resident service contracts are reviewed by the Administrator within 30 days of admission to ensure the resident service contract includes the evacuation floor plan and that the contract is accurate and complete. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | The QA committee will review new admission resident service contracts quarterly.<br><br>The QA committee will review new admission resident service contracts quarterly to ensure the evacuation floor plan is attached and that the contract is accurate and complete.<br><br>The Administrator completes new admission paperwork with the resident and/or representative and ensures the resident service contract is accurate ant complete. |

| | |
|---|---|
| | The resident service contract will continue to be monitored as stated above and by the QA committee quarterly. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 10/21/2019 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | |
|---|---|
| **Administrator's Signature** Administrator signature required. OAC 310:663-25-4(F) | **Date 9/6/2019** |

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<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 9/6/2019**<br>**Facility Name:** Go Ye Village Continuum of Care Retirement Community<br>**License Number:** CC1101AL<br>**Survey Event ID:** 03NZ11<br>**Date Survey Completed: 8/9/2019** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 1326 | Based on: Based on record review and interview, it was determined the center failed to ensure resident contracts contained a clear statement of the charges for additional services for 1 (#4) of 8 sampled residents. This failed practice had the isolated potential for more than minimal harm. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction Go Ye Village Continuum of Care Retirement Community does not admit that the deficiencies listed on the HCFA 2567 exists, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts and conclusions that form the basis for each deficiency.

| **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? | Resident #4 was admitted under a Respite admission contracted and paid for through Cherokee Elder Care (PACE). Resident #4 received upon admission a clear statement of the charges for additional services which stated all services are covered by Cherokee Elder Care (PACE) under the Respite admission contract. Resident #6, a Lifecare resident who is referenced in the second paragraph, has received a clear statement of charges for additional services on the addendum to the Life Care Agreement. However, a new resident services contract, which also lists optional services available for an additional fee, has been provided to resident #6 along with the Life Care Agreement and addendum to the Life Care Agreement. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | Upon admission all residents are provided a resident service contract which lists optional services available for an additional fee. Life Care residents currently residing in the Assisted Living Neighborhood have been provided a new resident services contract, which lists optional services available for an additional fee, along with the Life Care Agreement and addendum to the Life Care Agreement. All current resident services contracts have been reviewed to ensure it contained a clear statement of the charges for additional services. |
| 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 resident service contracts are reviewed by the Administrator within 30 days of admission to ensure the contract contains a clear statement of the charges for additional services and that the contract is accurate and complete. |

| | |
|---|---|
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | The QA committee will review new admission resident service contracts quarterly.<br><br>The QA committee will review new admission resident service contracts quarterly to ensure a clear statement of the charges for additional services was provided and that the contract is accurate and complete.<br><br>The Administrator completes new admission paperwork with the resident and/or representative and will ensure the resident service contract contains a clear statement of the charges for additional services and that the contract is accurate and complete.<br><br>The resident service contract will continue to be monitored as stated above and by the QA committee quarterly. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 10/21/2019 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | **Date 9/6/2019** |
| 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.<br>Facility in Compliance by: Click here to enter a date. | |

SEP 1 [illegible]

Oklahoma State Department of Health
Creating a State of Health

December 13, 2019

License Number: CC1101AL

Mr. Jerry Unruh, Administrator
Go Ye Village Continuum Of Care Retirement Communi
1201 West 4th Street
Tahlequah, OK 74464

**RE: Survey Event 03NZ12**

Dear Mr. Unruh:

On **November 13, 2019,** a desk audit revisit was conducted by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **August 9, 2019,** have now been corrected effective **October 21, 2019.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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 |
|---|---|---|---|
| | CC1101AL | A BUILDING: _____ B WING _____ | R 11/13/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GO YE VILLAGE CONTINUUM OF CARE RETIR | 1201 WEST 4TH STREET TAHLEQUAH, OK 74464 |

| (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<br><br>A desk audit survey was conducted 11/13/19. Credible evidence was submitted and all deficient practice was cleared. | {C 000} | | |

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

# *STATE WORKLOAD REPORT*

| Provider/Supplier Number | Provider/Supplier Name |
|---|---|
| CC1101AL | GO YE VILLAGE CONTINUUM OF CARE RETIREMENT COMMUNI |

Type of Survey (select all that apply)

| | | | | |
|---|---|---|---|---|
| 2 D | | | | |

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

| | | | | |
|---|---|---|---|---|
| A | | | | |

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

## SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

| Surveyor ID Number (A) | First Date Arrived (B) | Last Date Departed (C) | Pre-Survey Preparation Hours (D) | On-Site Hours 12am-8am (E) | On-Site Hours 8am-6pm (F) | On-Site Hours 6pm-12am (G) | Travel Hours (H) | Off-Site Report Preparation Hours (I) |
|---|---|---|---|---|---|---|---|---|
| Team Leader ID 1. [illegible]34460 | 11/13/2019 | 11/13/2019 | 0.50 | 0.00 | 0.00 | 0.00 | 0.00 | 0.50 |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
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| 12. | | | | | | | | |
| 13. | | | | | | | | |
| 14. | | | | | | | | |

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**