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Delivery via email to: [ALED@COUNTRYSIDETLC.COM](mailto:ALED@COUNTRYSIDETLC.COM)

February 24, 2025

License Number: AL1101

Ms. Carla Gay, Executive Director  
Countryside Assisted Living Of Tahlequah  
1380 N Heritage Lane  
Tahlequah, OK 74464

**RE: Survey Event ID: 8U4311**

Dear Ms. Gay:

On **February 13, 2025**, agents from our office concluded a State Licensure survey with a complaint investigation 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 **February 13, 2025**.

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:

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](mailto:IDRCoordinator@health.ok.gov), or telephone at (405) 426-8200.



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If you have questions or need assistance, please feel free to send an email to [LTCEnforcement@health.ok.gov](mailto: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

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## INVESTIGATIVE REPORT

**Facility:** Countryside Assisted Living of Tahlequah  
**Address:** 1380 N Heritage Lane  
**City, State, Zip:** Tahlequah, OK. 74464  
**Provider #:** AL1101  
**Complaint #:** OK00074711  
**Investigation Date:** 02/12/25 through 02/13/25

ALLEGATION(S)
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1. The facility failed to provide sufficient supervision to prevent elopement..
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An unannounced on-site investigation was initiated 02/12/2025 at 10:30 a.m.

A sample of three participants, including any identified participants, 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:** A tour of the facility was conducted upon entrance into the center. Residents were observed for signs of wandering and elopement seeking behaviors. Facility exterior doors were observed. Records reviewed included: Residents health records, facility reported incidents, grievances, resident rights, and elopement policies. Residents and staff were asked questions regarding elopement.

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: 02/13/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AL1101</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/13/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1380 N HERITAGE LANE TAHLEQUAH, OK 74464</b>
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(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	<p>INITIAL COMMENTS</p> <p>A relicensure survey was conducted from 02/12/25 through 02/13/25. A complaint investigation (#OK00074711) was conducted in conjunction with the survey.</p> <p>Facility Census: 31</p>	C 000		
C 391 SS=D	<p>310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE</p> <p>(a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure hair nets were worn in the kitchen during 1 of 2 kitchen observations.</p> <p>The administrator identified 31 residents received nutrition from the kitchen.</p> <p>Findings:</p> <p>An undated facility "Hygiene of Staff" policy, read in part, "All food service employees shall wear appropriate clothing including hairnet and shall keep themselves and their clothing clean."</p> <p>On 02/12/25 at 5:30 p.m., a tour of the kitchen was conducted. Cook #1 was observed in the kitchen preparing food and not wearing a hair net.</p> <p>On 02/12/25 at 5:32 p.m., cook #1 was asked what the policy was for wearing a hair net while working in the kitchen. Cook #1 stated they did</p>	C 391		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AL1101</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/13/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1380 N HERITAGE LANE TAHLEQUAH, OK 74464</b>
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(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 391	Continued From page 1  not wear a hair net because they had short hair.  On 02/13/25 at 9:02 a.m., the dietary manager was asked what the policy was wearing a hair net. The dietary manager stated all employees should be wearing a hair net while working in the kitchen	C 391		



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**Delivery via email to:** carla@countrysideltc.com

February 27, 2025

License Number: AL1101

Ms. Carla Gay, Executive Director  
Countryside Assisted Living of Tahlequah  
1380 N Heritage Lane  
Tahlequah, OK 74464

**RE: Survey Event 8U4311**

Dear Ms. Gay:

On **February 13, 2025**, a Re-licensure inspection with a complaint investigation 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 **April 13, 2025**.

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  
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:** 2/24/2025

**Facility Name:** Countryside Assisted Living of Tahlequah

**License Number:** AL1101

**Survey Event ID:** 8U4311

**Date Survey Completed:** 2/13/2025

**SUMMARY OF DEFICIENCY CITED BY OSDH**

ID Prefix Tag: C 391

Based on: observation, record review, and interview, the center failed to ensure hair nets were worn in the kitchen during 1 of 2 kitchen observations.

**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:  
 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.

OSDH Response: Element accepted Yes  No

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes  No

**Administrator's Signature** Carla Gay LPN, ED

OAC 310:663-25-4(F)

**Date** 2/24/2025

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.

<b>Addendum Date</b>	Enter a date of addendum.	<b>Submitted by</b>	Enter name of person submitting addendum.
<b>Items Below Are For OSDH Use Only</b>			
Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable Date: <a href="#">Click here to enter a date.</a> Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: <a href="#">Click here to enter text.</a>			
Facility in Compliance by: <a href="#">Click here to enter a date.</a>			



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Delivery via email to: [carla@countrySIDelTC.com](mailto:carla@countrySIDelTC.com)

April 15, 2025

License Number: AL1101

Ms. Carla Gay, Executive Director  
Countryside Assisted Living Of Tahlequah  
1380 N Heritage Lane  
Tahlequah, OK 74464

**RE: Survey Event 8U4312**

Dear Ms. Gay:

On **April 14, 2025**, an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **February 13, 2025**, have now been corrected effective **April 13, 2025**.

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AL1101</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>04/14/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1380 N HERITAGE LANE</b> <b>TAHLEQUAH, OK 74464</b>
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(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
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{C 000}	<p><b>INITIAL COMMENTS</b></p> <p>An offsite/paper revisit was conducted on 04/14/25. The facility was in substantial compliance.</p>	{C 000}		
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Oklahoma State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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