OKLAHOMA
State Department
of Health

Delivery via email to: lisa@countrysideltc.com

July 22, 2026

License Number: AL1101

Ms. Lisa Hawkins, Administrator
Countryside Assisted Living Of Tahlequah
1380 N Heritage Lane
Tahlequah, OK 74464

RE: Survey Event ID: 76HV11

Dear Ms. Hawkins:

On **July 15, 2026**, 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 **July 15, 2026**.

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 II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH
Address: 1380 N HERITAGE LANE
City, State, Zip: TAHLEQUAH, OK 74464
Provider #: AL1101
Complaint #: OK00090227
Investigation Date(s): 07/13/26-07/15/2026

ALLEGATION(S)
The center failed to ensure adequate nutrition to prevent avoidable weight loss.
The center failed to ensure medications were administered on time according to the physician orders
The center failed to ensure discharge procedures were completed according to state law.

An unannounced on-site investigation was initiated 07/13/2026 at 11:30 a.m.

A sample of nine 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:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways and common areas were observed for staff assistance and interactions between staff and residents as well as the presence of obnoxious and/or foul odors.

Resident council minutes, incident reports, policies and procedures, menus, admission and discharge records, and medication administration records were reviewed.

Staff members, the ombudsman, residents and family members were interviewed regarding care, admission and discharge process, medication administration, menus and dietary services.

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: 07/15/2026

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
	AL1101	A. BUILDING: _____ B. WING _____	C 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE ASSISTED LIVING OF TAHLEQUAH	1380 N HERITAGE LANE 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 A relicensure survey with complaint (#OK00090227) was conducted from 07/13/26 through 07/15/26. Deficiencies were cited. Facility Census: 40	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (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. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. the food in the refrigerators were labeled, dated, and covered, b. fresh vegetables were free of mold, c. refrigerators were free of spillage and standing water, d. refrigerators and freezer temperatures were checked and documented, e. dishwasher sanitizer levels and water temperatures were checked and documented, f. employees wore hair and beard nets, g. dry storage was maintained in a manner to prevent rodent/pest infestation, and h. food storage containers were air-dried and not stacked wet during 3 of 3 kitchen observations: The administrator identified that 40 residents received nutrition from the kitchen.	C 391		

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C 391	Continued From page 1 Findings: On 7/13/26 at 2:00 p.m., an initial tour of stand-up refrigerators in the kitchen was conducted. The following observations were made: a. a metal bowl with fresh grapes was not labeled, dated, or covered; b. a metal pan with fresh cucumber was observed with visible signs of spoilage, incluiding white, fuzzy growth; c. standing water was observed in the bottom of the stand-up refrigerator by the dietary manager's office; d. packaged bread was observed without labels or dates; e. single serve bowls of green jello with fruit were not labeled, dated, or covered; f. an opened 32-ounce container of coffee creamer was not labeled or dated; and g. a 64-ounce container of buttermilk was observed with a manufacturer "best by" date of 07/05/26. On 7/13/26 at 2:00 p.m., an initial tour of the dry storage area in the kitchen was conduted. The following observations were made: a.a package of au gratin potatoes with a manufacturer "best by" date of 06/27/26; b. four packages of twelve-inch tortillas with a manufacturer "best by" date of 08/14/25; c.an opened 49.6-ounce container of cornbread stuffing mix with an expiration date of 05/29/26; d.an opened 8.5-ounce package of blueberry muffin mix not sealed or in an airtight container; and e an opened package of quick five-minute grits not sealed or in an airtight container.	C 391		

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C 391	Continued From page 2 On 07/13/26 at 2:00 p.m., an initial tour of the main area of the kitchen was conducted. The following observations were made: a. two square plastic storage containers were stacked together with visible water in between each item; b. refrigerators and freezer temperatures were not documented; c. dishwasher sanitizer levels and water temperatures were not documented; and d. two employees with visible hair and facial hair exposed were observed not wearing hair or beard nets. On 07/14/26 at 9:00 a.m., the following observations were made: a. No thermometer was visible in the small chest freezer in the prep area; and b. two thermometers in the refrigerator next to dietary manager's office showed different temperature readings. The outside temperature on the stand-up refrigerator showed 35 degrees Fahrenheit and the inside thermometer showed 42 degrees Fahrenheit. A third thermometer was observed not registering any temperature. On 07/14/26 at 12:20 p.m., the dietary manager was observed with visible hair and beard. They were not observed to have worn a hair net or beard net in the kitchen and serving area. An undated "Sanitizer Solution Level Daily Shift Log," reviewed on 7/13/26 at 2:20 p.m., showed no documentation for the month of July 2026. A "Record of Refrigeration Temperatures," reviewed on 7/13/26 at 2:20 p.m., showed no documentation for the month of July 2026.	C 391		

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C 391	Continued From page 3 An undated policy titled "Dry Storage," read in part, "open packages will be stored in closed containers were tightly secured." On 07/13/26 at 2:00 p.m., Cook #2 stated they did not know if refrigerator temperatures were checked or logged. On 07/13/26 at 2:00 p.m., Cook #1 stated they had only worked in the kitchen for a couple of months and did not know anything about checking the dishwasher for sanitation or temperatures. On 07/13/26 at 2:05 p.m., the dietary manager stated they should check the sanitizer and temperatures on the dishwasher twice a day. They stated the refrigerators and freezers needed functioning thermometers and temperature readings completed daily. The dietary manager stated they had been on vacation, and the temperature readings looked like none of it had been documented. The dietary manager stated all molded and expired items should have been discarded. On 07/15/26 at 12:07 p.m., the administrator stated the sanitizer and temperature for the dishwasher should be checked every day. They stated overnight staff were supposed to make sure dishes were dry and put away. The administrator stated food items should be labeled when they were opened with use by dates and should be covered. The administrator stated the dry open food items should be in sealed containers. The adminstrator stated hair nets and beards nets should be worn at all times while in food preparation areas.	C 391		

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C 397	Continued From page 4	C 397		
C 397 SS=E	310:663-3-8(d)(4) FOOD STORAGE, PREPARATION AND SERVICE (4) Only clean, whole eggs with shell intact, pasteurized liquid, frozen, dry eggs, egg products and commercially prepared and packaged hard boiled eggs may be used. All eggs shall be thoroughly cooked except pasteurized egg products or pasteurized in-shell eggs may be used in place of pooled eggs or raw or undercooked eggs. This Rule is not met as evidenced by: Based on observation and interview, the center failed to ensure unpasteurized eggs were served in a manner to prevent foodbourne illness for 2 of 2 meal service observations. The administrator identified 40 residents served meals out of the kitchen. Findings: On 07/13/26 at 2:00 p.m., unpasteurized whole shell eggs were observed in the kitchen refrigerator. On 07/14/26 at 8:21 a.m., during breakfast, a soft cooked egg with runny yolk was observed served to a resident. On 07/13/26 at 2:00 p.m., the dietary manager stated they were not aware there was a regulation that eggs needed to be pasteurized. The dietary manager stated all regular shell eggs were served scrambled, fried, sunny side-up or over easy, and in other menu items.	C 397		

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C 397	Continued From page 5 On 07/15/26 at 12:07 p.m., the administrator stated they were not aware they needed to use pasteurized eggs.	C 397		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the direct care staff were trained in first aide and cardiopulmonary resuscitation for 1 (CMA #3) of 3 sampled direct care employees reviewed for staffing requirements. The administrator identified 19 direct care staff members. Findings: On 07/14/26 at 3:30 p.m., a review of CMA #3 employee file showed a hire date 3-21-26. The file showed no first aide and cardiopulmonary resuscitation training documentation. On 07/15/26 at 9:15 a.m., the administrator stated there were no records to show first aide and cardiopulmonary resuscitation training had been completed for CMA #3.	C 954		