OKLAHOMA
State Department
of Health

Delivery via email to: cdaves@lanemgmt.com; shellydrywater@gmail.com

September 1, 2026

License Number: AL2102

Casey Daves, Administrator
Lane Assisted Living Of Pryor
1300 Damon Drive
Pryor, OK 74361

RE: Survey Event ID: Z50M11

Dear Ms. Daves:

On **August 20, 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 **August 20, 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:

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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2102	A. BUILDING: _____ B. WING _____	08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANE ASSISTED LIVING OF PRYOR	1300 DAMON DRIVE PRYOR, OK 74361

(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 was conducted on 08/20/26. Deficiencies were cited. Facility Census: 11	C 000		
C 391 SS=D	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 expired foods in the dry storage area were discarded during 3 of 3 kitchen observations. The administrator identified 11 residents received nutrition from the kitchen. Findings: On 08/20/26 at 9:33 a.m., an initial tour of the kitchen dry storage area was conducted. The following observations were made: a. an unopened one-pound bag of mini marshmallows had a discard date of 07/06/26; b. an opened 12-ounce bag of mini semi-sweet chocolate chips had a discard date of 09/2025; c. an unopened 12-ounce bag of mini semi-sweet chocolate chips had a discard date of 12/2025; and d. two unopened 12-ounce bag of mini semi-sweet chocolate chips had a discard date of 03/2026.	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 391	Continued From page 1 A facility in-service document titled "FOOD STORAGE and SANITATION," dated 07/06/26, showed kitchen staff were educated on storing and identifying food with the use by date label. On 08/20/2026 at 4:15 p.m., the administrator stated expired food items should have been discarded.	C 391		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed once every 12 months for 1 (#4) of 5 sampled residents reviewed for comprehensive assessments. The administrator identified 11 residents resided in the facility. Findings: An annual assessment for Resident #4, dated 05/08/25, showed the assessment was the most current annual assessment completed. There was no documentation in Resident #4's medical record to show an annual assessment had been completed after 05/08/25. On 08/20/26 at 3:30 p.m., the administrator stated the annual assessment for Resident #4	C 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 521	Continued From page 2 had not been completed.	C 521		

OKLAHOMA
State Department of Health

Delivery via email to: cdaves@lanemgmt.com; shellydrywater@gmail.com

September 2, 2026

License Number: AL2102

Casey Daves, Administrator
Lane Assisted Living Of Pryor
1300 Damon Drive
Pryor, OK 74361

RE: Survey Event Z50M11

Dear Casey Daves:

On **August 20, 2026**, 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 **September 2, 2026**.

We will conduct a revisit to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

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Oklahoma State Department of Health

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C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed once every 12 months for 1 (#4) of 5 sampled residents reviewed for comprehensive assessments. The administrator identified 11 residents resided in the facility. Findings: An annual assessment for Resident #4, dated 05/08/25, showed the assessment was the most current annual assessment completed. There was no documentation in Resident #4's medical record to show an annual assessment had been completed after 05/08/25. On 08/20/26 at 3:30 p.m., the administrator stated the annual assessment for Resident #4	C 521	Refer to POC Template Survey Event ID# Z50M11 ID Prefix Tag C521	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 521	Continued From page 2 had not been completed.	C 521		

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/1/2026** **Facility Name:** Lane Assisted Living of Pryor **License Number:** AL2102 **Survey Event ID:** Z50M11 **Date Survey Completed: 8/20/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: observation, record review and interview, the center failed to ensure expired foods in the dry storage area were discarded during 3 of 3 observations.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Plan of Correction is submitted to comply with federal and state requirements and does not constitute an admission by the facility or its employees that the deficiency existed or that the findings are accurate.

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?	A thorough check of all dry goods in the storage area was conducted to ensure all expired foods were safely discarded.
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 11 residents living in the center at the time had the potential to be affected.
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?	Center manager or designee will conduct a monthly audit on all food storage areas to maintain safe use by date protocol.
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.	The center manager or designee will conduct a monthly audit of all food storage areas to maintain safe use by date protocol using a written audit tool. Any identified items which are expired will be safely discarded. The audit tool will be submitted no less than monthly to the administrator. Findings will be reported for QA monitoring, review and recommendations. The tracking tool/audit records will be maintained onsite in a log book.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/2/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator Signature required OAC 310:663-25-4(F)	**Date 9/1/2026**

Abby L Davis, LNHA

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/1/2026** **Facility Name:** Lane Assisted Living of Pryor **License Number:** AL2102 **Survey Event ID:** Z50M11 **Date Survey Completed: 8/20/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C521	Based on: record review and interview, the center failed to ensure comprehensive assessments were completed once every 12 months for 1 resident (#4).

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Plan of Correction is submitted to comply with federal and state requirements and does not constitute an admission by the facility or its employees that the deficiency existed or that the findings are accurate.

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's annual assessment was completed. Family was notifed of the error in completion of the assessment.
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 11 residents living in the center had the potential to be affected.
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?	Use of a tracking tool/calendar will be implemented and include all resident assessment due dates.
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.	The center manager or designee will utilize a calendar or tracking tool to include all resident assessment due dates. The administrator will perform an audit once monthly to ensure use the calendar. Any identified errors in completion will be addressed and completed immediately. Findings will be reported for QA review and recommendations and monitored to ensure continued compliance. The tracking tool and audit will be maintained onsite in a log book.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/2/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Casey L Bates, LNHA	**Date 9/1/2026**	

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.

AUDIT: Food Storage Audit for Expired Foods

DATE: Sept 2026 AUDITOR: _____
COMMENTS: _____

DATE: Oct 2026 AUDITOR: _____
COMMENTS: _____

DATE: Nov 2026 AUDITOR: _____
COMMENTS: _____

DATE: Dec 2026 AUDITOR: _____
COMMENTS: _____

DATE: Jan 2027 AUDITOR: _____
COMMENTS: _____

DATE: Feb 2027 AUDITOR: _____
COMMENTS: _____

DATE: Mar 2027 AUDITOR: _____
COMMENTS: _____

DATE: Apr 2027 AUDITOR: _____
COMMENTS: _____

DATE: May 2027 AUDITOR: _____
COMMENTS: _____

DATE: June 2027 AUDITOR: _____
COMMENTS: _____

DATE: July 2027 AUDITOR: _____
COMMENTS: _____

AUDIT: Assessments Tracking - Due date/Completion Date

DATE: Sept 2026 AUDITOR: _____
COMMENTS: _____

DATE: Oct 2026 AUDITOR: _____
COMMENTS: _____

DATE: Nov. 2026 AUDITOR: _____
COMMENTS: _____

DATE: Dec. 2026 AUDITOR: _____
COMMENTS: _____

DATE: Jan 2027 AUDITOR: _____
COMMENTS: _____

DATE: Feb 2027 AUDITOR: _____
COMMENTS: _____

DATE: Mar 2027 AUDITOR: _____
COMMENTS: _____

DATE: Apr 2027 AUDITOR: _____
COMMENTS: _____

DATE: May 2027 AUDITOR: _____
COMMENTS: _____

DATE: June 2027 AUDITOR: _____
COMMENTS: _____

DATE: July 2027 AUDITOR: _____
COMMENTS: _____