OKLAHOMA
State Department
of Health

Delivery via email to: lpn_583@yahoo.com

August 7, 2026

License Number: AL2502

Ms. Dana Vandever, Administrator
The Willows
301 Melville Drive
Pauls Valley, OK 73075

Survey Event ID: KEX611

Dear Ms. Vandever:

On **July 21, 2026,** representatives from the Oklahoma State Department of Health (OSDH) concluded a Relicensure survey with a complaint investigation at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 will be completed for each violation; and
(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 a 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: **The Willows**
Address: **301 Melville Dr**
City, State, Zip: **Pauls Valley, OK 73075**
Provider #: **AL2502**
Complaint #: **OK00092081**
Investigation Date(s): **07/20/26 and 07/21/26**

ALLEGATION(S)
The facility failed to ensure residents were not verbally abused, and/or intimidated.
The facility failed to protect residents from misappropriation.
The facility failed to report allegations of abuse to the OSDH.

An unannounced on-site investigation was initiated 07/20/2026 at 10:20a.m.

A sample of 8 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: Observations of staff to resident ratio, staff to resident interactions, medication passes and appearance of residents were made. Records of incident reports, resident health charts, service plans, assessments, physician orders, resident medications, and center policies were reviewed. Interviews with residents, staff and family members were conducted. Based on observation, record review, and interview, no deficiencies were cited.

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: 07/22/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **The Willows**
Address: **301 Melville Dr**
City, State, Zip: **Pauls Valley, OK 73075**
Provider #: **AL2502**
Complaint #: **OK00092150**
Investigation Date(s): **07/20/26 and 07/21/26**

ALLEGATION(S)
The facility failed to ensure residents were free from abuse.
The facility failed to ensure care was provided to meet the needs of the residents.
The facility failed to ensure allegations of abuse were reported per state regulations.

An unannounced on-site investigation was initiated 07/20/2026 at 10:20a.m.

A sample of 8 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: Observations of staff to resident ratio, staff to resident interactions, medication passes and appearance of residents were made. Records of incident reports, resident health charts, service plans, assessments, physician orders, resident medications, and center policies were reviewed. Interviews with residents, staff and family members were conducted. Based on observation, record review, and interview, no deficiencies were cited.

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: 07/22/2026

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
	AL2502	A. BUILDING: _____ B. WING _____	C 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

(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 complaints (#OK00092150 and #OK00092081) was conducted from 07/20/26 through 07/21/26. Deficiencies were cited. Facility Census: 38 Listed below are abbreviations that will be used throughout this document. CNA- certified nursing assistant	C 000		
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 foodborne illness for all residents for 1 of 1 kitchen observation. The administrative assistant identified 38 residents received nutrition from the kitchen. Findings: On 07/20/26 at 11:00 a.m., a tour of the kitchen was conducted. Unpasteurized whole shell eggs	C 397		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2502	A. BUILDING: _____ B. WING _____	C 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

(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 397	Continued From page 1 were observed in the walk in refrigerator. On 07/20/26 at 11:30 a.m., Cook #1 stated they did not know there was a regulation that eggs needed to be pasteurized. Cook #1 stated all regular shelled eggs were served scrambled, fried, sunny side up, or over easy. Cook #1 stated three residents were served fried eggs. On 07/20/26 at 11:35 a.m., Cook #2 stated they did not know that there was a regulation that eggs needed to be pasteurized. Cook #2 stated all regular shelled eggs were served scrambled, fried, sunny side up, or over easy. Cook #2 stated three residents were served fried eggs.	C 397		
C1972 SS=C	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure abuse training was completed within 90 days of hire for 2 (CNA #2 and CNA #3) of 6 sampled staff reviewed for abuse training. The administrative assistant identified 38 residents resided in the center. Findings:	C1972		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2502	A. BUILDING: _____ B. WING _____	C 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

(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
C1972	Continued From page 2 An employee record for CNA #2 showed the CNA was hired in 01/2026. There was no documentation to show CNA #2 had completed abuse training. An employee record for CNA #3 showed the CNA was hired in 01/2026. There was no documentation to show CNA #3 had completed abuse training. On 07/21/26 at 4:08 p.m., the administrator stated the abuse training for CNA #2 and CNA #3 had not been completed.	C1972		

OKLAHOMA
State Department
of Health

Delivery via email to: lpn_583@yahoo.com

August 31, 2026

License Number: AL2502

Ms. Dana Vandever, Administrator
The Willows
301 Melville Drive
Pauls Valley, OK 73075

Survey Event ID: KEX611

Dear Ms. Vandever:

On **July 21, 2026,** a Relicensure survey with a complaint investigation was conducted at your Assisted Living Center. 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 in a timely manner. **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 **August 31, 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,

Tempal Killman

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

Enclosure

The Willows AL will exclusively purchase pasteurized eggs moving forward. This decision follows discussions between Dana Vandever, Administrator, and Michael Dobbins, Director. The Dietary Supervisor and all dietary staff have been trained on the new policy. The Dietary Supervisor oversees all food and grocery ordering for the facility and will no longer procure unpasteurized eggs. Using only pasteurized eggs ensures that no current or future residents are at risk of foodborne illness. All eggs used for cooking, baking, boiling, and frying will be pasteurized.

OKLAHOMA State Department of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: August 19, 2026
Facility Name: The Willows Assisted Living
License Number: AL2502
Survey Event ID: KEX611
Date Survey Completed: July 21, 2026

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C397	Based on: Observation and interview, the center failed to ensure unpasteurized eggs were served in manner to prevent foodborne illness for all residents for 1 of 1 kitchen observation.

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	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?	The Willows AL will only purchase pasteurized eggs going forward.This decision was made after conversation between Dana Vandever, Administrator and Michael Dobbins, Director. The Dietary Supervisor and all dietary staff were in-serviced on the new policy. The Dietary Supervisor is in charge of the food and grocery ordering for our facility. She will no longer purchase eggs that are unpasteurized. The use of ONLY pasteurized eggs in our facility ensures that no current or future residents will be at risk of food borne illness due to the use of unpasteurized eggs. Only pasteurized eggs will be used for all cooking, baking, boiling and frying purposes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Without the change of using only pasteurized eggs, there would always be the possibility that a dietary worker could mistakenly use an unpasteurized egg in an unsafe manner. The Willows AL identifies all current and future residents as being potentially affected without this change. Our facility is committed to only purchasing pasteurized eggs for all cooking purposes for this reason.
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?	The Willows AL will ONLY purchase and use pasteurized eggs in our facility. This systemic change will ensure that the potential use of unpasteurized eggs being prepared in an unsafe manner will be avoided.
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.	Enter methods to ensure corrections are sustained: All dietary staff were in-serviced on the risk of foodborne illness due to the use of unpasteurized eggs. An egg that is fried in a way that the yolk is not fully hard, could potentially cause illness if the egg is not pasteurized. Enter methods to evaluate for effectiveness: The Dietary Supervisor is now ONLY allowed purchase pasteurized eggs. The use of only pasteurized eggs will eliminate the risk of an egg being served in a way that is unsafe. Enter methods to incorporate into QA system: Quarterly order sheets from our food supplier; US Food, will be presented at each Quality Assurance meeting. These order sheets will show that only pasteurized eggs are being purchased for use in our facility. Enter methods to keep monitoring records: Each Tuesday, when the weekly grocery order is received from US Foods, Egg case of eggs will be visually observed by the dietary supervisor and the administrator to ensure that each case of eggs is correctly labeled as Pasteurized. Individual pasteurized eggs area each stamped with a "P" making identification easy and fool proof. This visual observation will be documented on a printed flow sheet that will be kept in the kitchen. Each shipment date will be dated and signed on this flow sheet indicating that newly delivered eggs are marked Pasteurized.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	July 31, 2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Dana D. Vandever, Administrator
Dana Vandever
OAC 310:663-25-4(F)

Date: August 19, 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.

OKLAHOMA State Department of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: August 19, 2026
Facility Name: The Willows Assisted Living
License Number: AL2502
Survey Event ID: KEX611
Date Survey Completed: July 21, 2026

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1972	Based on: Record review and interview, the center failed to ensure abuse training was completed within 90 days of hire for 2 (CNA #2 and CNA#3) of 6 sampled staff reviewed for abuse training.

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	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?	On July 29, 2026, Abuse and Neglect In-Service and Training was conducted. Ombudsman Supervisor; Rebekah Williams, presented an in-service and training called Empowering staff through awareness and responsibility. This was mandatory for all staff. CNA#2 and CNA#3 were both in attendance.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident, present and future, living at our facility is identified as potentially being affected if staff are not properly trained in a timely manner on abuse training.
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?	Each employee file folder will now contain a check sheet attached that will list required training as well as required certifications. This check sheet will include the date that abuse and neglect is required to be completed, the date training has been completed and proof of such training will be kept in each employee file.
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.	Enter methods to ensure corrections are sustained: All newly employed resident care staff member will have date of hire listed and tracked, not only the administrators computer calendar but also on the administrative assistance's computer calender. This calendar will also be marked with the date that abuse training must be completed; within (90) days of employement. Enter methods to evaluate for effectiveness: Administrator will conduct regular monthly audits of employee files and training records, confirm that all new staff complete abuse and neglect training within 90 days of hire, observe staff adherence to training protocols during daily routines. Enter methods to incorporate into QA system: The administrator will provide current staffing reports, containing employee name and hire date at each quarterly meeting. Employee training records will be presented and reviewed by Quality Assurance members. QA members will be able to match current staff names, hire date, and date of abuse and neglect training records to ensure each have received training within the required 90 day period from employment. Enter methods to keep monitoring records: Records will be kept in each employee file. The check sheet that list, date of hire and required training dates, will be attached to each employee file for easy review. A copy of proof of completed abuse and neglect training will be placed in each employee file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	August 31,2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Dana D. Vandever, Administrator Dana Vandever	**Date: August 20, 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.

OKLAHOMA
State Department
of Health

Delivery via email to: lpn_583@yahoo.com

September 17, 2026

License Number: AL2502

Ms. Dana Vandever, Administrator
The Willows
301 Melville Drive
Pauls Valley, OK 73075

RE: Survey Event KEX612

Dear Ms. Vandever:

On **September 16, 2026,** an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **July 21, 2026,** have now been corrected effective **August 31, 2026.**

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 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
	AL2502	A. BUILDING: _____ B. WING _____	R-C 09/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

(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 An offsite/paper revisit was conducted on 09/16/26. All deficiencies from the 07/21/26 survey were cleared.	{C 000}		

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