
Delivery via email to: rharvey@ardmorevillage.com

November 26, 2025

License Number: AL1002

Rhonda Harvey, Administrator
Village Lodge Of Ardmore Village
1310 Knox Road
Ardmore, OK 73401

RE: Survey Event ID: CE2L11

Dear Ms. Harvey:

On **November 18, 2025**, 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 **November 18, 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: 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
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Village Lodge of Ardmore Village
Address: 1310 Knox Road
City, State, Zip: Ardmore, OK 73401
Provider #: AL1002
Complaint #: OK00086749
Investigation Date(s): 11/10/25, 11/12/25, 11/13/25, 11/17/25 and 11/18/25

ALLEGATION(S)
The center failed to provide staffing to meet the needs of the residents.
The center failed to ensure interventions were in place to prevent falls.
The center failed to ensure residents were not admitted above the level of care the center could provide.
The center failed to ensure bed alarms were not used as restraints.

An unannounced on-site investigation was initiated 11/10/2025 at 9:50 a.m.

A sample of seven residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 throughout the investigation. Residents were observed on all halls and units. Residents were observed during meals, while receiving medications, during activities, and while interacting with staff. Residents were observed for appropriate supervision to prevent falls. Residents were observed for any type of restraint. Staff members were observed for adequate staffing to meet the needs of residents. Staff were observed for prompt response to resident needs.

Sampled clinical records were reviewed for physician orders, care plans, progress notes and assessments. Assessments were reviewed for appropriate placement of residents. Incident reports were reviewed for appropriate interventions to prevent falls. Staffing schedules and employee records were reviewed. Facility policies and procedures were reviewed.

Residents were interviewed regarding adequate staffing to meet their needs. Residents were interviewed regarding supervision, assistance, and interventions to prevent falls. Family members were interviewed on the memory care unit related to resident safety and sufficient staffing. Staff members were interviewed regarding adequate staffing for the reported resident census and resident acuity. Staff were interviewed regarding interventions to prevent falls and the facility restraint policy.

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: 11/18/2025

INVESTIGATIVE REPORT

Facility: Village Lodge of Ardmore Village
Address: 1310 Knox Road
City, State, Zip: Ardmore, Ok. 73401
Provider #: AL1002
Complaint #: OK00067170
Investigation Date(s): 11/10/25, 11/12/25, 11/13/25, 11/17/25 and 11/18/25

ALLEGATION(S)

The facility failed to ensure residents were not over-sedated.
The facility failed to notify family/legal surrogate of a change in resident's condition
The facility failed to protect residents from misappropriation of medications.

An unannounced on-site investigation was initiated 11/10/2025 at 09:50 a.m.

A sample of 7 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 throughout the investigation. Residents were observed to be assisted by staff during meals, during medication administration, and while participating in activities with dignity and respect. Residents were observed to be alert and not sedated.

Sampled clinical records were reviewed for medication administration records, physician orders, care plans, assessments and hospital admission and discharge records. Incident reports were reviewed. Facility policies and procedures were reviewed. Staff in-service trainings were reviewed.

Residents, staff and family members were interviewed regarding medication administration, and notification with changes in condition.

The attached CMS 2567 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: 11/18/2025

INVESTIGATIVE REPORT

Facility: Village Lodge of Ardmore Village
Address: 1310 Knox Road
City, State, Zip: Ardmore, Ok. 73401
Provider #: AL1002
Complaint #: OK00083627
Investigation Date(s): 11/10/25, 11/12/25, 11/13/25, 11/17/25 and 11/18/25

ALLEGATION(S)

The facility failed to implement infection control measures to prevent COVID-19.
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An unannounced on-site investigation was initiated 11/10/2025 at 09:50 a.m.

A sample of 7 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 throughout the investigation. Residents were observed to be assisted by staff during meals, during medication administration, and while participating in activities.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Incident reports were reviewed. Facility policies and procedures were reviewed. Staff in-service trainings were reviewed.

Residents, staff and family members were interviewed regarding measures to prevent COVID-19.

The attached CMS 2567 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: 11/18/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/18/2025
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(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 (#OK00067170, OK00083627, and #OK00086749) was conducted on 11/10/25, 11/12/25 through 11/13/25, and 11/17/25 through 11/18/25. Deficiencies were cited as a result of the survey. Facility Census: 43 Listed below are abbreviations that will be used throughout this document. CNA - certified nursing assistant DM - dietary manager DON - director of nursing	C 000		
C 391 SS=E	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 facility failed to ensure the kitchen was maintained to promote food safety and sanitation. The executive director identified 43 residents resided in the facility. Findings:	C 391		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/18/2025
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(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 On 11/12/25 at 4:05 p.m., a tour of the kitchen was conducted. A trash can was observed open, with no lid by the sink/eyewash station. On 11/12/25 at 4:10 p.m., the evening meal service was observed. The following observations were made: a. CNA #1 and CNA #2 were observed to wear gloves to receive plates and cups with resident food and drinks in the kitchen and then wore the gloves to the dining area to serve food to residents. CNA #1 and CNA #2 were observed touching doors and counters and then receiving the next resident's plate and cup without changing gloves. CNA #1 was observed using a pen to write in a notebook with the same gloves used to continue serving the residents; b. dietary/kitchen staff #1 was observed serving food at a heated table and then cleaning the area with the same gloves while food was being taken by other staff to the dining area. Dietary/Kitchen Staff #1 served food for the next resident without changing gloves. Dietary/Kitchen Staff #1 updated a document with a pen using the same gloves and returned to serve the next resident's food without changing gloves; c. dietary/kitchen staff #2 was observed to pick up a foam cup from the floor with gloves on and continued to serve food with the same gloves; and d. CNA #1 was observed to use a small scoop to serve mayonnaise from a large container with the same gloves used to serve food in the dining area. On 11/12/25 at 4:17 p.m., cook #1 was observed to pick up a notebook and pen from the counter then started to serve food again without changing gloves.	C 391		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/18/2025
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(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 2 An undated facility kitchen policy showed food handlers trash bins must be durable, cleanable, and pest-resistant with tight-fitting lids. An undated facility glove policy showed gloves should be changed: a. as soon as they become soiled or torn; b. before beginning a different task; c. at least every four hours during continual use, and more often if necessary; and d. after handling raw meat, seafood, or poultry and before handling ready to eat food. On 11/12/25 at 4:17 p.m., cook #1 reported they did not know what the facility policy was related to changing gloves. Cook #1 was asked about the trash can and reported they did not know where the lid was and did not remember ever seeing it with a lid. On 11/12/25 at 4:24 p.m., cook #2 reported they thought the facility policy was to change gloves as needed. On 11/13/25 at 9:14 a.m., the DM reported staff should not be going in and out of the kitchen wearing the same gloves. The DM reported staff should change gloves any time there was a chance they were dirty or contaminated. The DM reported they were aware of the trash can without a lid and would get it replaced.	C 391		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident;	C 522		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/18/2025
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(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 522	Continued From page 3 (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days after admission for 1 (#3) of 7 residents sampled for assessments. The executive director identified 43 residents resided in the facility. Findings: The facility did not provide an assessment policy. An Oklahoma State Department of Health resident assessment form (comprehensive assessment) for Resident #3, dated 06/25/25, showed the resident was admitted to the facility on 06/05/25. The form showed the resident had diagnoses which included cerebrovascular accident and dementia. On 11/17/25 at 2:10 p.m., the DON reported Resident #3's comprehensive assessment was not completed within the required 14 days after admission.	C 522		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and	C 542		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/18/2025
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(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 542	Continued From page 4 signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an assessment was completed with the coordination of a registered nurse or physician for 1 (#6) of 7 residents sampled for assessments. The executive director identified 43 residents resided in the facility. Findings: The facility did not provide an assessment policy. Resident #6's health and service evaluation results, dated 04/17/25, showed the resident was independent with mobility, transferring and bathing. The evaluation had not been signed to indicate a registered nurse or physician had coordinated with the facility to complete the assessment. Resident #6's physician order review, dated 11/13/25, showed the resident had diagnoses which included anemia, depression, and diabetes. On 11/18/25 at 9:40 a.m., the DON reported the evaluation was for Resident #6's annual assessment and it had not been coordinated with a registered nurse or physician.	C 542		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/18/2025
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(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	

Delivery via email to: rharvey@ardmorevillage.com

December 26, 2025

License Number: AL1002

Ms. Rhonda Harvey, Executive Director
Village Lodge Of Ardmore Village
1310 Knox Road
Ardmore, OK 73401

RE: Survey Event CE2L11

Dear Ms. Harvey:

On **November 18, 2025**, 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 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 have been corrected and you were in substantial compliance by **December 5, 2025**.

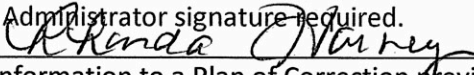
We will conduct a revisit to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
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: 12/9/2025		
	Facility Name: Village Lodge of Ardmore Village		
	License Number: AL 1002		
	Survey Event ID: CE2L11		
Date Survey Completed: 11/18/2025			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C391		Based on: observation, C N A #1 and C N A #2 cook #1 cook #2 observed wear gloves to receive plates and cups with resident food and drinks in the kitchen and cook pick up notebook then started seving food without changing gloves. Cook #2 unclear of policy	
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?		Inservice staff on mandatory compliance of food safety and sanitation and proper wearing of gloves.	
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 residents have the potential to be affected. Inservice staff on 11/21/2025 on food safety and sanitation.	
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?		Culinary team inservice and role played correct wearing of gloves for servers, food staff and cooks.	
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.		Inservice all staff and provided additional training if applicable. Added discrepancies to upcoming QA to review progress and outcomes. Updated policies for current staff. Continuing monitoring of food safety and sanitation. Weekly Checks Discussions at daily stand up Records archived with standard record reporting and in training binder.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/21/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. 		Date 12/9/2025	
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.			
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: 12/9/2025

Facility Name: Village Lodge of Ardmore Village

License Number: AL 1002

Survey Event ID: CE2L11

Date Survey Completed: 11/18/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522

Based on: based on record review and interview the facility failed to ensure a comprehensive assessment was completed within 14 days after admission for 1(#3) of 7 residents sampled for assessments

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:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- 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 Administrator signature required.
OAC 310:663-25-4(F)

Date 12/9/2025

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.

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: 12/9/2025

Facility Name: Village Lodge of Ardmore Village

License Number: AL 1002

Survey Event ID: CE2L11

Date Survey Completed: 11/18/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542

Based on: record review and interview, the facility failed to ensure an assessment was completed with the coordination of a registered nurse or physician 1 (#6) of 7 residents sampled for assessments.

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:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- 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 ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #6 assessment has been signed by a registered nurse and placed in chart.

All residents have the potential to be affected. Team has been inserviced on the importance of RN and/or physician coordination, review and signature.

Audit of charts to ensure compliance of all assessments are signed by RN and/or physician. New move in assessments and 14 day, annual assessments placed in red flag folder for RN review and signatures.

Inserviced all staff on the importance of RN and/or physician review and signatures for all assessments. Added discrepancies to upcoming QA to review progress and outcomes. Updated policies for current assessment process.

Monthly audits of resident assessments

QA ongoing topics metrics discussed and met

Review process and revise as needed.

12/5/2025

Administrator's Signature Administrator signature required.
OAC 310:663-25-4(F)

Date 12/9/2025

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.

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.

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.

Delivery via email to: rharvey@ardmorevillage.com

December 11, 2025

License Number: AL1002

Ms. Rhonda Harvey, Administrator
Village Lodge Of Ardmore Village
1310 Knox Road
Ardmore, OK 73401

RE: Survey Event CE2L11

Dear Ms. Harvey:

On **November 18, 2025**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **All Cited Deficiencies** - The Plan of Correction does not show who will monitor and/or audit new processes or corrections, or for how long this will take place.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
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: 12/11/2025

Facility Name: Village Lodge of Ardmore Village

License Number: AL 1002

Survey Event ID: CE2L11

Date Survey Completed: 11/18/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522

Based on: based on record review and interview the facility failed to ensure a comprehensive assessment was completed within 14 days after admission or 1(#3) of 7 residents sampled for assessments.

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:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- 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 Administrator signature required.

OAC 310:663-25-4(F)

Date Enter a date of signature.

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Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

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ASSISTED LIVING CENTER'S PLAN ELEMENTS

DON has completed any outstanding assessments and it has been placed in chart. Team has been inserviced on the importance of a 14 day assessment upon admission.

All residents have the potential to be affected. DON/ADON has inserviced staff on 14 day assessments upon admission.

ED/DON have implemented new move in checklist and move in board with date deadline for 14 day assessments.

ED/DON implemented move in board with 14 day assessments reminders. ED/DON added discrepancies to upcoming QA to review progress and outcomes. ED/DON updated policies for staff.

ADON providing monthly audits of residents files/charts

QA meetings with ED/DON/CD/MD reviewing 14 day assessments

ED/DON review process and revise as needed.

Click here to enter a date when corrective action will be completed. 12/5/2025

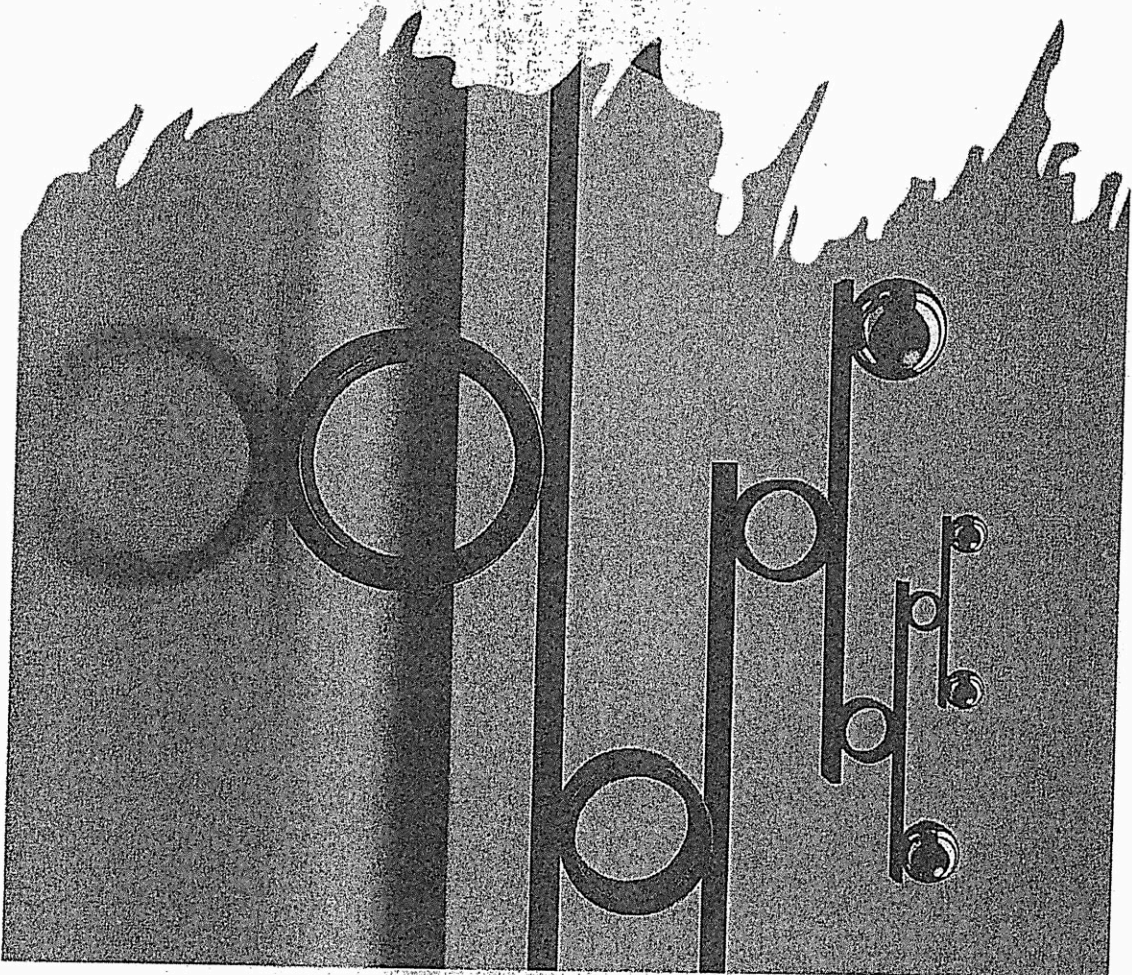
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

C522

**Ardmore Village The Lodge
Quality Assurance
14-Day Assessment Review**

QA Comprehensive Resident Centered Care Plans & Resident Assessments

- Intent
- Promote continuity of care
- Communication among care staff
- Increase resident safety
- Safeguard against adverse events that are most likely to occur right after admission
- Ensure the resident and representative if applicable are informed of the initial plan for delivery of care and services by written summary of a 14 day assessment. This is imperative after admission which provides a baseline care plan.
- The care plan should strike a balance between conditions and risks affecting the resident's health and safety, and what is important to him or her, within the limitations of the care plan timeframe.





What is Person Centered Care

The facility focuses on the resident as the center of control, and supports each resident in making his or her own choices.

This includes making an effort to understand: What each resident is communicating, verbally and nonverbally
Identifying what is important to each resident with regard to daily routines and preferred activities
having an understanding of the resident's life before coming to reside in the assisted living facility.

Documentation

Goals, objectives and include interventions that address his or her current needs. It must be based on the admission orders. Information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.

14 Day Assessments

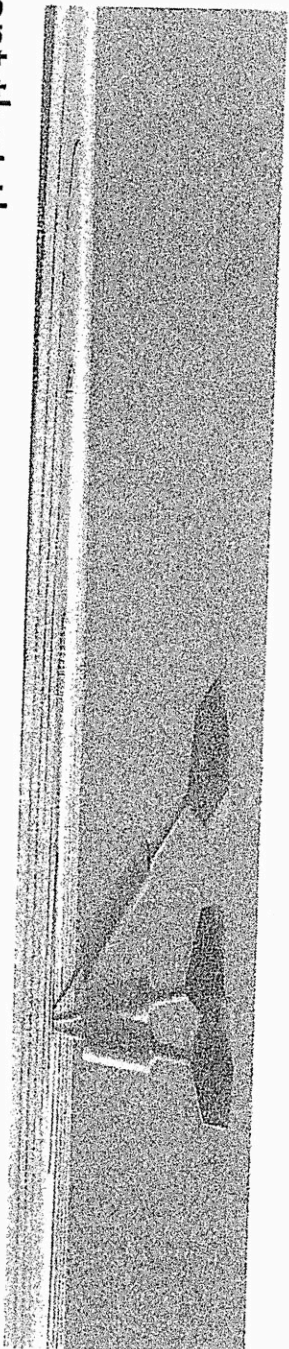
- The facility must develop and implement a 14-day assessment for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

- Care Plans Summary
- The initial goals of the resident
- A summary of the resident's current medications and dietary instructions.
- Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
- Any updated information based on the details of the comprehensive care plan, as necessary.

The summary must be in a language and conveyed in a manner the resident and/or representative can understand.

The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable. The facility may choose to provide a copy of the care plan itself as the summary, as long as it meets all of the requirements of the summary.

Goals



- In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable.
- Once the comprehensive care plan has been developed and implemented, and a summary of the updates given to the resident, the facility is no longer required to revise/update the written summary of the care plan. Rather, each resident will remain actively engaged in his or her care planning process through the resident's rights to participate in the development of, and be informed in advance of changes to the care plan; see the care plan; and sign the care plan after significant changes.

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI) FORM

Meeting Date: _____

Facilitator: _____

Quarter: ☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4 Year: _____

QAPI Review Topics Recorder: _____

Location: _____

Resident Health Outcomes / Care	Date: _____	Staff: _____	Comments: _____
Resident Satisfaction	Date: _____	Staff: _____	Comments: _____
Incidents / Falls	Date: _____	Staff: _____	Comments: _____
Infection Control	Date: _____	Staff: _____	Comments: _____
Resident Safety	Date: _____	Staff: _____	Comments: _____
Resident Concerns / Complaints	Date: _____	Staff: _____	Comments: _____
Organizational Performance Improvement	Date: _____	Staff: _____	Comments: _____
Human Resources Management	Date: _____	Staff: _____	Comments: _____
Management of Information	Date: _____	Staff: _____	Comments: _____
Follow-Up / Action Items	Date: _____	Staff: _____	Comments: _____

Issue / Action / Responsible / Target Date / Completion: _____

Committee Attendance

Name / Title: _____ Signature: _____

Name / Title: _____ Signature: _____

Summary / Recommendations: _____

Next QAPI Meeting Date: _____

Approval Signatures

Administrator / DON: _____ Date: _____

QA Coordinator / Committee Chair: _____ Date: _____

2250

Training Sign-in Sheet

Training Description	14 day Assessment / Good Samaritan
Purpose	Survey Citation Review & Compliance
Date and Duration	11/21/24

[illegible]

Facilitator Name:

Facilitator Signature:



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/11/2025

Facility Name: Village Lodge of Ardmore Village

License Number: AL 1002

Survey Event ID: CE2L11

Date Survey Completed: 11/18/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542

Based on: based on record review and interview the facility failed to ensure a assessment a was completed with the coordination of a registered nurse or physician for 1(#6) of 7 residents sampled for assessments.

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:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- 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 Administrator signature required.
OAC 310:663-25-4(F)

Date 12/11/2025

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.

Addendum Date

Enter a date of addendum.

Submitted by

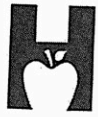
Enter name of person submitting addendum.

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Facility in Compliance by: Click here to enter a date.



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/11/2025

Facility Name: Village Lodge of Ardmore Village

License Number: AL 1002

Survey Event ID: CE2L11

Date Survey Completed: 11/18/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: observation, record review, and interview, the facility failed to ensure the kitchen was maintained to promote food safety and sanitation.

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:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- 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

OAC 310:663-25-4(F)

Administrator signature required

Date 12/11/2025

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Addendum Date Enter a date of addendum.

Submitted by

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ASSISTED LIVING CENTER'S PLAN ELEMENTS

Culinary Director inserviced staff on mandatory compliance of food safety and sanitation.

All residents have the potential to be affected. Culinary Director inserviced staff on 11/21/2025 on food safety and sanitation.

Purchased new trash container with attached lids with foot pedals to ensure compliance of proper sanitation processes. This is placed and will be used going forward.

Culinary Director/Executive Director inserviced all staff and Culinary Director will provide additional training when applicable. Added discrepancies to upcoming QA to review process and outcomes. Continuing monitoring of food safety and sanitation and report the updates at stand up meetings provided by Culinary Director and/or ED

Weekly Checks by Culinary Director

Review at daily stand up with leadership team.

Records archived with standard record reporting.

Click here to enter a date when corrective action will be completed 11/21/2025

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.

ULINE

1-800-295-5510
uline.com

ORDER CONFIRMATION

ORDER # 43938815
PO # RHONDA
SHIPMENT 1 of 1

Thank you for your order!

SOLD TO: ARDMORE VILLAGE
1310 KNOX ROAD
ARDMORE OK 73401
US

SHIP TO: ARDMORE VILLAGE
1310 Knox Road
ATTN: Kitchen Dish Plt
ARDMORE OK 73401
US

C391

CUSTOMER NUMBER			SHIP VIA	ORDER DATE	SHIP DATE	TERMS
33953034			UPS GROUND	12/09/25	12/09/25	VISA
QUANTITY	U/M	ITEM NUMBER	DESCRIPTION	UNIT PRICE	EXT. PRICE	
1	EA	H-2670BL	RUBBERMAID® STEP-ON TRASH CAN - 23 GALLON, BLACK	235.00	235.00	
1	EA	S-26429	2026 MANITOWISH WATERS CALENDAR THIS ITEM AT NO CHARGE	.00	.00	
SUB-TOTAL			235.00	SALES TAX	21.44	SHIPPING/HANDLING
					26.58	TOTAL
						283.02

NOTE:

DELIVERY TIME 1 BUSINESS DAY VIA UPS GROUND.

SHIPMENT #1 SHIPPED 12/09/25

ATTENTION: RHONDA HARVEY

CHECK ORDER STATUS

* Utilized closed did
until new hot
can arrived

0391

Ardmore Village The Lodge Kitchen Trash Policy 01/2025 to Present

In Oklahoma, food handlers' trash bins must be **durable, cleanable, and pest-resistant** with **tight-fitting lids**. They should be emptied frequently enough to prevent odors and pests, and the surrounding area must be kept clean and free of litter and debris. All waste must be disposed of properly to avoid contaminating food or creating unsanitary conditions.

Internal and external trash bin requirements

- **Pest-proof:** Bins must be designed to prevent insects and rodents from accessing the waste.
- **Durable and cleanable:** Receptacles should be made of a non-absorbent material that can be easily cleaned and disinfected.
- **Tight-fitting lids:** All containers, both for internal and external use, must have secure lids.
- **Frequent disposal:** Waste must be disposed of often enough to prevent odors and the attraction of pests.
- **Proper placement:** External waste storage areas should be located away from food preparation and delivery zones.
- **Cleanliness:** The area around waste bins must be regularly cleaned, and the bins themselves should be washed and emptied according to a schedule. We change out our trash food bin after each meal.

Waste disposal and facility requirements

- **Liquid waste:** Wastewater must be disposed of into a sanitary sewer or other approved system, and disposal into storm sewers is prohibited.
- **No overflow:** Do not allow trash cans to overflow or pile up.
- **Grounds maintenance:** The area surrounding the facility should be clean and free from debris that could harbor pests.
- **Prevent contamination:** Waste must be managed in a way that it does not constitute a source of contamination to food, equipment, or utensils.



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/11/2025

Facility Name: Village Lodge of Ardmore Village

License Number: AL 1002

Survey Event ID: CE211

Date Survey Completed: 12/11/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: observation , C N A #1 and C N A @2 cook #1 cook #2 observed wear gloves to receive plates and cups with resident food and drinks in the kitchen and cook pck up notebook then started serving food without changing gloves. Cook #2 unclear of policy

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:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- 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 Administrator signature required.

OAC 310:663-25-4(F)

Date 12/11/2025

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Enter name of person submitting addendum.

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Facility in Compliance by: [Click here to enter a date.](#)

C 391

part (2)

ps

Handwashing

Improper handwashing techniques are the number one cause of cross-contamination. To prevent this, all team members should properly wash their hands after any act that they might have picked up a contaminate. This includes, but not limited to: coughing, sneezing, touching hair, smoking, handling potentially hazardous food, handling equipment or going to the restroom. The proper handwashing technique is to use as hot of water as you can stand, but at least 100 degrees. Use soap and scrub your hands together for at least 20 seconds, making sure you get between fingers and under fingernails. Rinse thoroughly after and dry your hands with a single use towel or hot air dryer. All handwashing should be done at a dedicated handwashing station that is stocked with hot water, soap and disposable towels.

Single Use Gloves

Single use gloves have become a symbol of food safety and can inspire a false sense of security. Using disposable gloves should be an addition, not a substitute, for proper handwashing.

The 2017 Food Code, section 3-301.11 states:

"Except when washing fruits and vegetables, food employees may not contact exposed ready to eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single use gloves or dispensing equipment."

Ready to eat food means food that is in a form that is in a form that is edible without additional preparation to achieve food safety.

The longer gloves are worn, the more likely their effectiveness as a barrier deteriorates. Associates should ideally replace their gloves every two hours at minimum to guard against possible unseen punctures. Always change gloves if the gloves are ripped, torn, contaminated or if you are changing to a different food task.

It is critical to ensure that team members properly wash their hands according to the Ardmore Village handwashing policy before putting on gloves and immediately after removing them. Gloves are meant to prevent bare-hand contact with food served to consumers. Many food service teams falsely think gloves are protecting their own hands. Single use gloves are to help reduce the spread of disease-causing organisms and cross contamination when used appropriately.

It is important for team members to know that single use gloves can offer additional food protection, if placed on washed hands and changed at appropriate times during the food operation.

When to Change Disposable Gloves

As soon as they become soiled or torn.