OKLAHOMA
State Department
of Health

Delivery via email to: kproctor@rcmseniorliving.com; lwood@rcmseniorliving.com

June 21, 2021

License Number: AL1412

Ms. Karen Proctor, Administrator
Village on The Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

Survey Event ID: YC3Z11

Dear Ms. Proctor:

On **May 25, 2021, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey 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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. 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.

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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 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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 or conducted in a face-to-face 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

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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.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.06.21 16:18:23 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Village on the Park**
Address: **1515 Kingsridge Drive**
City, State, Zip: **Oklahoma City, OK 73170**
Provider #: **AL1412**
Complaint #: **#OK00055055**
Investigation Date(s): **05/24/21 through 05/25/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide sufficient staff to meet the needs of the residents.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/24/2021 at 09:20 a.m.

A sample of nine 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-0962 for details.

An investigation specific to sufficient staff to meet the needs of the residents was investigated. A tour was conducted of the center, observations of the center and nursing documentation and closed records were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation one. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Julie Edmiaston By Ed Roh

Julie Edmiaston RN, BSN

Date report completed: 05/26/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Village on the Park**
Address: **1515 Kingsridge Drive**
City, State, Zip: **Oklahoma City, OK 73170**
Provider #: **AL1412**
Complaint #: **#OK00056334**
Investigation Date(s): **05/24/21 through 05/25/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents received adequate and appropriate medical care.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/24/2021 at 09:20 a.m.

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

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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-1505 for details.

An investigation specific to medication administration was investigated. The nursing notes, medication administration records contained in a closed record was investigated. Medication administration policy and procedure were included.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation one. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Julie Edmiaston By Esdm

Julie Edmiaston RN, BSN

Date report completed: 05/26/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Village on the Park**
Address: **1515 Kingsridge Drive**
City, State, Zip: **Oklahoma City, OK 73170**
Provider #: **AL1412**
Complaint #: **#OK00057056**
Investigation Date(s): **05/24/21 through 05/25/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to protect residents from neglect.	**US**

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/24/2021 at 09:20 a.m.

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

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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to an allegation of abuse/mistreatment for an injury of unknown source was investigated. Staffing schedules were reviewed, incident reports, and documentation.

It was determined an incident for an injury of unknown source occurred on 04/16/21; however, the center investigated the incident immediately. The employee identified on the center's cameras and interviewed was suspended during the investigation to protect other residents and the employee was terminated on 04/19/21 for negligence. The resident assessment and plan of care documented the resident required an one person assist for toileting. The DRC (direct care coordinator) utilized the center's cameras to narrow down the possible employees who entered the resident's room on that night. An investigative report dated on 04/17/21 determined

after employee interviews one employee acknowledged she left the resident unattended on the toilet when she was distracted by a family member of another resident. The Oklahoma State Department of Health (OSDH) requested additional documents on 05/04/21, which the center reported they had not received. The form 718 (Notification of Nurse Aide/Nontechnical Service Worker Registry) with the resident's discharge diagnosis and treatment for a closed fracture of right proximal humerus, and the termination notice of employee involved in the incident was faxed to OSDH on 05/10/21.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation one. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Julie Edmiaston By ESign

Julie Edmiaston RN, BSN

Date report completed: 05/25/2021

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
	AL1412	A. BUILDING: _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE PARK - OKLAHOMA CITY	1515 KINGSRIDGE DRIVE OKLAHOMA CITY, OK 73170

(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 On 05/24/21 through 05/25/21, a complaint investigation was conducted for complaint #OK00057056, #OK00055055, and #OK00056334. The following deficient practice was cited.	C 000		
C 962 SS=E	310:663-9-6(b) MINIMUM STAFF FOR SERVICES (b) A continuum of care facility or assisted living center that has only one direct care staff member on duty shall: (1) Disclose the one-person staffing and the plan for dealing with urgent and emergent situations to residents and their representatives before admission or prior to one-person staffing if such staffing was not previously practiced by the assisted living center; and, (2) Have in place a plan, approved by the Department, for dealing with urgent or emergent situations, including resident falls, during periods when the assisted living center has only one direct-care staff member on duty. This Rule is not met as evidenced by: Based on interview and record interview, it was determined the center failed to ensure one person staffing and a plan to deal with emergent situations was disclosed to the residents and their representatives and such plan was approved by the Department. This deficient practice had the potential for more than minimal harm for 1 (#4)	C 962		

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C 962	Continued From page 1 and widespread potential for all 27 residents with the potential for falls. Findings: On 05/24/21 at 9:35 a.m., advanced certified medication aide (ACMA) #1 stated the center had been short of staff for the past two months. The memory care unit is separated from the assisted living side by a locked door on the memory care unit. At 10:30 a.m., the director of resident care (DRC)/licensed practical nurse (LPN) stated when she conducted assessments for admissions to the center, she did not admit people who would be beyond a two-person assist. If residents required a mechanical lift, she would not admit them. At 12:45 p.m., the executive director (ED) was asked if the fire department was called out to lift residents off of the floor. She stated as far as she knew they had not been called out for the assisted living side or the memory care side. She stated it would have been for the independent living side. At 3:06 p.m., the ED notified licensed practical nurse (LPN) #6 by telephone who had worked at the center around 02/09/2020. LPN #6 stated resident #4 had behaviors and she would throw herself to the floor. She stated resident #4 would have required 1:1 care if she returned to the center after she was transferred to another facility for an evaluation on 02/12/2020, because of behaviors. She stated there was several times they had to call the fire department to get resident #4 up off the floor. At 4:30 p.m., the ED was asked if she disclosed	C 962		

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C 962	Continued From page 2 one person staffing and had a plan for emergent situations in place approved by the department. She stated no, because she thought two people would count because its' all under the same license and that's why there is two people here so they can help each other. Licensed practical nurse (LPN) #6 was asked about an incident on 02/09/2020 when resident #4 fell and the fire department was notified. She stated resident #4 fell between the bed and the dresser on 02/09/2020 and they did call the fire department to get her up. She stated resident #4 was a large woman and the fire department would make sure she was OK. She stated resident #4 was transferred out of the memory care unit on 02/12/2020 to another facility for an evaluation, and she did not return to the center. At 3:40 p.m., the DRC/LPN was asked how many times a month was there only one direct patient care staff in the memory care unit and one direct patient care staff person on the assisted living side. She stated never during the day shift and a couple times a month on night shift. On 05/25/21 at 8:20 a.m., ACMA #2 was asked if there were times when the center had one direct care staff person on the memory care unit and one direct care staff person on the assisted living side. She stated more times than it should have happened. She stated it did not happen so much on the day shift, but more often on the night shift. She stated on day shift for Mother's Day the center had one staff person for the memory care unit and one staff person for the assisted living side. ACMA #2 and ACMA #5 were the only staff on duty for both the memory care unit and the assisted living side.	C 962		

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C 962	Continued From page 3 At 9:20 a.m., ACMA #1 and ACMA #2 both reported frequent staffing on night shift with only one staff person on the memory care unit and one staff person on the assisted living side. They both reported resident #1, 7, and #9 at times could require two-person assist on the memory care unit. At 9:52 a.m., ACMA #5 was asked if she worked on Mother's Day. She stated she worked on Mother's Day and after 8:30 a.m., that morning there was one staff member for the memory care unit and one staff member for the assisted living side. She was asked if she had ever notified the fire department to pick a resident up off the floor. She stated one time we were going to call the fire department, but three of us was able to get resident #6 up off the floor.	C 962		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated,	C1505		

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C1505	Continued From page 4 and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to obtain a signed physician's order for Hydroxchloroquine. Additionally, the center failed to inform the Power of Attorney for one (#2) of two sampled residents with closed clinical records to review for consistent established and recognized medical practice standards. These deficient practices resulted in the isolated potential for more than minimal harm. Findings: Policy: The center's policy titled, 'Medication Delivery-Pharmacy, Resident, or Family Members' not dated, documented, only the Community Nurse and/or designee may receive and sign for medication deliveries...The staff	C1505		

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C1505	Continued From page 5	C1505		

member will verify the receipt of the correct medications as ordered upon delivery from the pharmacy; any discrepancies in the order should be noted on the delivery manifest.

The staff member will not accept any medications that are not ordered for the resident. If there is a discrepancy, the pharmacy should be notified immediately, so corrective measures can be taken. All delivered medications will have a current order on file. If no order is on file, the Community Nurse will be notified.

Resident #2's assessment dated 03/09/2020, documented, Dementia, Chronic Kidney Disease, and Renal Failure. Alert x 1, confused, forgetful, poor judgment, and poor short- and long- term memory (very jumbled verbiage), on hospice services.

On 05/24/21 at 12:00 p.m., the executive director (ED) was asked to review resident #2's closed clinical record. She stated he passed away on 04/30/2020. A copy of the Power of Attorney (POA) was located in the record.

The ED was asked about the Hydroxychloroquine administered to resident #2. She explained the center's previous LPN #7 notified the center's attending physician and exchanged text messages on April 19, 2020 and the physician sent a text for Hydroxychloroquine 200 mg twice daily for five days for someone named "Jones" on hospice and LPN #7 offered to call the medication in to the pharmacy.

The ED was asked about the signed physician's order for Hydroxychloroquine. She stated there was not one. She was asked about the center's policy to notify the POA when a new medication

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C1505	Continued From page 6 was ordered. She stated it was the center's practice to call the POA. She stated the previous LPN #7 did not notify the POA for a new medication order for Hydroxychloroquine. The ED was asked if a verbal order was written for the Hydroxychloroquine in the closed record. She stated no, the order was called in to the pharmacy by the previous LPN #7. She stated LPN #7 was no longer employed at the center. The Hydroxychloroquine was delivered by a local pharmacy to the center and was administered at 9:00 a.m., on April 22, 2020 and the last dose was administered at 8:00 p.m., on April 26, 2020, for a total of five days.	C1505		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to maintain an organized, accurate clinical record for: a) one (#2) of one sampled resident with a negative test for Covid-19 and an elevated temperature with no documented evidence the resident's Power of Attorney (POA) was informed of the Hydroxycholorquine treatment. b) one (#4) of one sampled resident with no	C1951		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1951	Continued From page 7 documentation of an increase in behaviors, falls, and a transfer to another facility for an evaluation. These deficient practices resulted in the potential for more than minimal harm for two (#2, and #4) of two sampled residents closed clinical records. Findings: Resident #2 On 05/24/21 at 12:00 p.m., the ED was asked about the signed physician's order for Hydroxychloroquine. She stated there was not one in the clinical record. She was asked about the center's policy to notify the POA when a new medication was ordered. She stated it was the center's practice to call the POA. She stated the previous LPN #7 did not notify/document the POA was consulted about the use of Hydroxychloroquine for Covid-19 like symptoms. Resident #4 On 05/24/21 at 3:22 p.m., the ED was asked about documentation of resident #4's increase of behaviors, frequent falls, or a transfer from the center on 02/12/2020 for an evaluation. She stated the staff were not good at documentation. She was asked if the closed record contained the reasons resident #4 did not return to the center after she was transferred out to another facility for an evaluation. She stated no, and nothing about a discussion of resident #4 needing 1:1 observation if she did return to the center. The ED was asked about an incident on 02/09/2020 when the fire department was called out to lift resident #4 off the floor. She stated nothing was documented in resident #4's closed	C1951		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1412	A. BUILDING: _____ B. WING _____	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE PARK - OKLAHOMA CITY	1515 KINGSRIDGE DRIVE OKLAHOMA CITY, OK 73170

(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
C1951	Continued From page 8 clinical record about the fire department being called out or about a fall on that day.	C1951		

OKLAHOMA
State Department
of Health

Delivery via email to: kproctor@rcmseniorliving.com;

July 21, 2021

License Number: AL1412

Karen Proctor, Administrator
Village On The Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

Survey Event ID: YC3Z11

Dear Ms. Proctor:

On **May 25, 2021**, agents from our office completed a complaint investigation 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:

- Each of the deficiencies will need to include the signature of the administrator.
- Tag C0962 - #3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? This plan element should not be dependent upon the "census of residents in the building" and will need to be corrected.

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

Sincerely,

Tempal Killman Digitally signed by Tempal Killman
Date: 2021.07.21 16:07:52 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care | Enforcement
Protective Health Services

TK/

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: 7/2/2021** **Facility Name:** Village on the Park-Oklahoma City **License Number:** AL 1412-1412 **Survey Event ID:** YC3Z11 **Date Survey Completed: 5/25/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C0962	Based on: Interview and record interview, it was determined the center failed to ensure one person staffing and a plan to deal with emergent situations was disclosed to the residents and their representatives and such plan was approved by the Department. This deficient practice had the potential for more than minimal harm for 1 and widespread potential for all 27 residents with the potential for falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Village on the Park Oklahoma City of the truth of alleged facts in this statement of the deficiency and plan of correction. This plan of correction is submitted to comply with the State regulations. This plan of correction serves as an allegation of compliance.

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?	Contracted the services of local staffing agencies to find additional staffing. If sufficient staffing is not available, DRC, ED, LEC or AL Manager will complete the shift.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	There will be a minimum of 3 staff at all times. DRC, AL Manager, LEC or ED will fill in shifts that are not complete, or families/residents/state will be notified of one person staffing.
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?	Depending on census of residents in the building, there will be a minimum of 3 on staff at all times. DRC, AL Manager, LEC or ED will fill in the shifts that are not complete. Attendance of staff will be monitored on a daily basis by DRC, ED or designee.
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.	DRC, ED or designee will routinely check staffing levels. Attendance of staff will be monitored on a daily basis by DRC, ED or designee. Evaluated at QA meeting. Staffing records will be kept in QA book. QA will be held once a month for 3 months beginning August 5, 20201, then quarterly thereafter.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/1/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date** Enter a date of signature.
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: 7/2/2021** **Facility Name:** Village on the Park-Oklahoma City **License Number:** AL1412-1412 **Survey Event ID:** YC3Z11 **Date Survey Completed: 5/25/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Interview and record review, it was determined the center failed to obtain a signed physician's order for Hydroxchloroquine. Additionally, the center failed to inform the POA for one of two sampled residents wih closed clinical records to review for consistent established and recognized medical practice standards.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Village on the Park Oklahoma City of the truth of alleged facts in this statement of the deficiency and plan of correction. This plan of correction is submitted to comply with the State regulations. This plan of correction serves as an allegation of compliance.

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?	DRC or designee will notify POA of any changes in medication prior to start of ordered medication. Audit of all charts was completed by Julia Gable, Corporate LVN during the week of June 7, 2021, to ensure that all medications have orders.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DRC or designee will verify any change in medication. DRC, CMA or designee will verify the receipt of the correct medications upon receipt from the pharmacy. All delivered medications will have current order on fiile.
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?	DRC will monitor orders on an ongoing basis. RN will monitor orders on an ongoing basis. DRC or designee will verify any change in medication. DRC, CMA or designee will verify the receipt of the correct medications upon receipt from the pharmacy. All delivered medications will have current order on fiile. Audit of all charts was completed by Corporate LVN during the week of June 7, 2021, to ensure that all medications have orders.
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.	DRC will monitor orders on an ongoing basis. Documentation into Point Click Care of when POA is notified of medication changes by DRC or designee. RN will do random audits of charts for 3 months beginning 8/5/21. Enter methods to incorporate into QA system:

	QA audits will be done by RN on a random basis. Will be reviewed at QA meetings every month for 3 months and quarterly thereafter.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	8/1/2021		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature.	
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: 7/2/2021
	Facility Name: Village on the Park-Oklahoma City
	License Number: AL1412=1412
	Survey Event ID: YC3Z11
	Date Survey Completed: 5/25/2021

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1951	Based on: Interview and record review, it was determined the center failed to maintain an organized, accurate clinical record for a) One of one sampled resident with a negative test for Covid-19 and an elevated temperature with no documented evidence the resident's POA was informed of the Hydroxcholorquine treatment, b) one of one sampled resident with no documentation of a increase in behaviors, falls, and a transfer to another facility for an evaluation

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Village on the Park Oklahoma City of the truth of alleged facts in this statement of the deficiency and plan of correction. This plan of correction is submitted to comply with the State regulations. This plan of correction serves as an allegation of compliance.

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 to staff concerning the importance of documentation by the CMA/ACMA/DRC of all resident incidents, behaviors, changes in condition on 6/1/21. Inservice completed by RN Consultant
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Continued education for staff of importance of documentation and change in resident condition. By documentation of resident changes, there will be understanding of the level of care needed for resident safety and well-being.
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?	DRC or designee on duty will check 24 hour log and/or be notified of a change in resident condition as well as check that staff are communicating on daily log. RN will randomly audit charts for proper documentation Staff inservice on correct procedure to document all incidents and changes in behavior for residents on 6/24/21 performed by RN Consultant. Complete Clinical Focus form provided by corporate office for all residents will be added to QA process
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	QA monthly beginning 8/5/21 with new DRC for 3 months, then continue quarterly. ED will keep record to verify QA progress Complete Clinical Focus form provided by corporate office for all residents will be added to QA process

c. How monitoring records will be kept to evidence the correction.	DRC and RN will do random audits of charts for documentation on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/1/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.

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: kproctor@rcmseniorliving.com;

July 30, 2021

License Number: AL1412

Ms. Karen Proctor, Administrator
Village On The Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

Survey Event ID: YC3Z11

Dear Ms. Proctor:

On **May 25, 2021,** 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 amended 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 **August 1, 2021**.

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

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.07.30 15:13:50 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care | Enforcement Division
Oklahoma State Department of Health

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/2/2021** **Facility Name:** Village on the Park-Oklahoma City **License Number:** AL 1412-1412 **Survey Event ID:** YC3Z11 **Date Survey Completed: 5/25/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C0962	Based on: Interview and record interview, it was determined the center failed to ensure one person staffing and a plan to deal with emergent situations was disclosed to the residents and their representatives and such plan was approved by the Department. This deficient practice had the potential for more than minimal harm for 1 and widespread potential for all 27 residents with the potential for falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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?	Contracted the services of local staffing agencies to find additional staffing. If sufficient staffing is not available, DRC, ED, LEC or AL Manager will complete the shift.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	There will be a minimum of 3 staff at all times. DRC, AL Manager, LEC or ED will fill in shifts that are not complete, or families/residents/state will be notified of one person staffing.
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?	There will be a minimum of 3 on staff at all times. 2 staff members will be assigned to Memory Care at all times. Staff will be inserviced for these practices by 8/1/21. DRC, AL Manager, LEC or ED will fill in the shifts that are not complete. Attendance of staff will be monitored on a daily basis by DRC, ED or designee.
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.	DRC, ED or designee will routinely check staffing levels. Attendance of staff will be monitored on a daily basis by DRC, ED or designee. Evaluated at QA meeting. Staffing records will be kept in QA book. QA will be held once a month for 3 months beginning August 5, 20201, then quarterly thereafter.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/1/2021

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature.	
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. 1/26/23	**Submitted by**	Enter name of person submitting addendum. Kara Peters
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: 7/2/2021** **Facility Name:** Village on the Park-Oklahoma City **License Number:** AL1412-1412 **Survey Event ID:** YC3Z11 **Date Survey Completed: 5/25/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Interview and record review, it was determined the center failed to obtain a signed physician's order for Hydroxchloroquine. Additionally, the center failed to inform the POA for one of two sampled residents wih closed clinical records to review for consistent established and recognized medical practice standards.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Village on the Park Oklahoma City of the truth of alleged facts in this statement of the deficiency and plan of correction. This plan of correction is submitted to comply with the State regulations. This plan of correction serves as an allegation of compliance.

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?	DRC or designee will notify POA of any changes in medication prior to start of ordered medication. Audit of all charts was completed by Julia Gable, Corporate LVN during the week of June 7, 2021, to ensure that all medications have orders.
OSDH Response: Element accepted Yes ☒ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DRC or designee will verify any change in medication. DRC, CMA or designee will verify the receipt of the correct medications upon receipt from the pharmacy. All delivered medications will have current order on fiile.
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?	DRC will monitor orders on an ongoing basis. RN will monitor orders on an ongoing basis. DRC or designee will verify any change in medication. DRC, CMA or designee will verify the receipt of the correct medications upon receipt from the pharmacy. All delivered medications will have current order on fiile. Audit of all charts was completed by Corporate LVN during the week of June 7, 2021, to ensure that all medications have orders.
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.	DRC will monitor orders on an ongoing basis. Documentation into Point Click Care of when POA is notified of medication changes by DRC or designee. RN will do random audits of charts for 3 months beginning 8/5/21. Enter methods to incorporate into QA system:

		QA audits will be done by RN on a random basis. Will be reviewed at QA meetings every month for 3 months and quarterly thereafter.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/1/2021	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Karen Puccio		**Date** Enter a date of signature. 7/2/24	
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: 7/2/2021** **Facility Name:** Village on the Park-Oklahoma City **License Number:** AL1412=1412 **Survey Event ID:** YC3Z11 **Date Survey Completed: 5/25/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1951	Based on: Interview and record review, it was determined the center failed to maintain an organized, accurate clinical record for a) One of one sampled resident with a negative test for Covid-19 and an elevated temperature with no documented evidence the resident's POA was informed of the Hydroxcholorquine treatment, b) one of one sampled resident with no documentation of a increase in behaviors, falls, and a transfer to another facility for an evaluation

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Village on the Park Oklahoma City of the truth of alleged facts in this statement of the deficiency and plan of correction. This plan of correction is submitted to comply with the State regulations. This plan of correction serves as an allegation of compliance.

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 to staff concerning the importance of documentation by the CMA/ACMA/DRC of all resident incidents, behaviors, changes in condition on 6/1/21. Inservice completed by RN Consultant
OSDH Response: Element accepted Yes ☒ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Continued education for staff of importance of documentation and change in resident condition. By documentation of resident changes, there will be understanding of the level of care needed for resident safety and well-being.
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?	DRC or designee on duty will check 24 hour log and/or be notified of a change in resident condition as well as check that staff are communicating on daily log. RN will randomly audit charts for proper documentation Staff inservice on correct procedure to document all incidents and changes in behavior for residents on 6/24/21 performed by RN Consultant. Complete Clinical Focus form provided by corporate office for all residents will be added to QA process
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	QA monthly beginning 8/5/21 with new DRC for 3 months, then continue quarterly. ED will keep record to verify QA progress Complete Clinical Focus form provided by corporate office for all residents will be added to QA process

c. How monitoring records will be kept to evidence the correction.		DRC and RN will do random audits of charts for documentation on a monthly basis.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/1/2021	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature.	7/2/21
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: kproctor@rcmseniorliving.com;

September 13, 2021

License Number: AL1412

Ms. Karen Proctor, Administrator
Village on the Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

RE: Survey Event YC3Z12

Dear Ms. Proctor:

On **September 10, 2021,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 25, 2021,** have now been corrected effective **August 1, 2021.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 426-8200.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.09.13 08:14:18
-05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

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
	AL1412	A. BUILDING: _____ B. WING _____	R 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE PARK - OKLAHOMA CITY	1515 KINGSRIDGE DRIVE OKLAHOMA CITY, OK 73170

(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 completed on 09/10/21. Credible evidence of correction was submitted for all deficiencies.	{C 000}		

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