OKLAHOMA
State Department
of Health

Delivery via email to: kproctor@cardinalbay.org

May 23, 2023

License Number: AL1412

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

RE: Survey Event ID: 851611

Dear Ms. Proctor:

On **May 11, 2023**, 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 May 11, 2023.

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 (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 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 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 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

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

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Village on the Park
Address: 1515 KINGSRIDGE DRIVE
City, State, Zip: OKLAHOMA CITY, OK, 73170
Provider #: AL1412
Complaint #: OK00060226
Investigation Date(s): 05/09/23 through 05/11/23

ALLEGATION(S)

1. The center failed ensure residents' representatives were notified of changes in condition.
2. The center failed to ensure certified, adequately trained staff were providing care for dependent residents.

An unannounced on-site investigation was initiated 05/09/2023 at 09:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Staff were observed interacting with residents and providing care. Staff were observed providing activities of daily living care and performing proper transfer techniques.

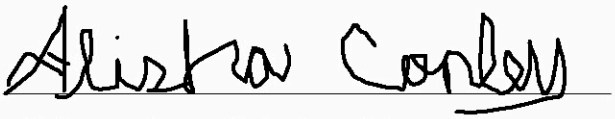
Resident records were reviewed including, service contracts, admission records, care plans, physician orders, nursing notes, treatment records, and incident reports. Facility policies and procedures were reviewed for emergency transfer protocols and sufficient qualified staffing. Staffing time sheets were reviewed. Staffing qualifications, training certificates, and education in-services were reviewed.

Residents were interviewed related to the quality of care they received, availability and qualifications of staff to meet their needs, and timely notification of their representatives after a change in their condition.

Staff members were interviewed regarding facility policies on the proper procedures used to transfer a resident to the emergency room including the proper paperwork to be sent with emergency medical services.

Deficient practice was not cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.



Alisha Conley, Clinical Health Facility Surveyor

Date report completed: 05/14/2023

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 _____	C 05/11/2023

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 A relicensure survey was conducted from 05/09/23 through 05/11/23. A complaint investigation (#OK00060226) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: CMA- certified medication aide CNA- certified nurse aide OSDH - Oklahoma State Department of Health	C 000		
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, 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	C1505		

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 _____	C 05/11/2023

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

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C1505	Continued From page 1 incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to provide safety checks every two hours per the service plan for three (#5, 6, and #8) of four residents reviewed for safety checks. The "Daily Census", dated 05/11/23, documented 18 residents resided in the Memory Care Unit. Findings: 1. Resident #5 was admitted with diagnoses which included dementia, mood disorder, and osteoporosis. A "Service Plan," dated 05/04/23, documented the resident required safety checks by staff every two hours. Task documentation dated for the last 27 days documented staff were to provide wellness checks every two hours. The task was not documented as completed 129 out of 324 opportunities.	C1505		

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

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C1505	Continued From page 2 2. Resident #6 was admitted with diagnoses which included dementia and major depressive disorder. A "Service Plan," dated 04/06/23, documented the resident required safety checks by staff every two hours. Task documentation dated for the last 29 days documented staff were to provide wellness checks every two hours. The task was not documented as completed 135 out of 348 opportunities. 3. Resident #8 was admitted with diagnoses which included dementia and seizures. A "Service Plan," dated 01/18/23, documented the resident required safety checks by staff every two hours. Task documentation dated for the last 29 days documented staff were to provide wellness checks every two hours. The task was not documented as completed 142 out of 348 opportunities. On 05/10/23 at 11:20 a.m., the Director of Resident Care was asked how often safety checks were to be documented. They reported every two hours. On 05/10/23 at 12:29 p.m., Certified Nurse Aide (CNA) #1 was asked how often safety checks were to be documented. CNA #1 reported every two hours. On 05/10/22 at 12:30 p.m., Certified Medication Aide (CMA #1) was asked how often safety checks were to be documented. CMA #1 reported	C1505		

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 _____	C 05/11/2023

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
C1505	Continued From page 3 every two hours.	C1505		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to submit an incident report to the OSDH related to an elopement for	C1911		

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 _____	C 05/11/2023

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
C1911	Continued From page 4 one (#6) of two residents reviewed for incident reports. The "Daily Census" documented 18 residents resided in the Memory Care Unit. Findings: A "Missing Resident" policy, undated, read in part, "...Follow state specific guidelines for reporting to regulatory agencies ..." Resident #6 was admitted with diagnoses which included dementia and major depressive disorder. On 05/09/23 at 2:11 p.m., the Director of Resident Care provided an in-house elopement report dated 09/11/22. They reported they could not locate the state reportable document for the incident. On 05/09/23 at 2:29 p.m., the Director of Resident Care was asked if the incident should have been reported to the OSDH. They replied "Yes." On 05/10/23 at 11:27 a.m., the Director of Resident Care was asked what the timeline was for reporting to OSDH. They reported 24 hours to report the initial report and five days for the final report.	C1911		

OKLAHOMA
State Department
of Health

Delivery via email to: kproctor@cardinalbay.org

June 27, 2023

License Number: AL1412

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

Survey Event ID: 851611

Dear Ms. Proctor:

On **May 11, 2023,** a Licensure inspection and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and 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 **July 1, 2023**.

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.

Respectfully,

Tempal Killman

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

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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/30/2023** **Facility Name:** Village on the Park Oklahoma City **License Number:** AL1412-1412 **Survey Event ID:** 851611 **Date Survey Completed: 5/11/2023**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: This requirement is not met as evidenced by: Based on observation, record review and interview, the center failed to provide safety checks every two hours per the service plan for three (#5, 6 and #8) of four residents reviewed for safety checks
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?	DRC will review all MC care plans to determine if resident requires 2 hour checks and adjust care plans accordingly
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	MC residents that are on 2 hour checks will have the service plan reviewed for the need for 2 hour checks. Adjustments to service plans will be made accordingly
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?	*Staff will be inserviced on importance of care plan checks and documentation in POC *Each resident's Plan of Care will be specific to the needs of the residents wellness check per health assessment. *DRC or designee will review POC 3 x week for compliance in a timely manner of documentation *Monthly QA meeting for 3 months for June, July and August to review compliance of POC documentation and all QA meetings thereafter *Monthly inservices for review of POC compliance in June, July, August and continued as needed
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 or designee will review POC 3 x week for compliance; Monthly QA meetings for June, July and August for compliance of documentation and all QA meetings thereafter Enter methods to evaluate for effectiveness: QA meetings will be held June, July, August to evaluation the POC documentation of required checks and all QA meetings thereafter DRC or designee will review POC 3 x week for compliance
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/1/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Karen Proctor, ED OAC 310:663-25-4(F)	**Date** Enter a date of signature. 5/30/23

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

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

OKLAHOMA State Department of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/30/2023

Facility Name: Village on the Park Oklahoma City

License Number: AL1412-1412

Survey Event ID: 851611

Date Survey Completed: 5/11/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1911	Based on: This requirement is not met as evidenced by: It was determined the center failed to submit an incident reort to the OSDH related to an elopement for one (#6) of two residents reviewed for incident reports

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?	DRC or designee will communicate all incidents to the ED within 24 hours. ED will ensure that all State Reports are filed in a timely manner within first day of business
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Safety of residents to ensure all reports are reported to the State within the first day of business All incident reports were reviewed to ensure that no other resident was affected by deficient practice
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?	ED will ensure that all state reports are submitted in a timely manner within the first day of business ED will keep log of all incidents reported by DRC Incidents will be reviewed in Stand Up for appropriate State Reportables ED will has completed continued education through OKALA for review of State regulations QA meeting in June, July, August to review all State Reportable incidents and ensure compliance that all have been reported in a timely manner and all QA meetings thereafter.
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.	QA meetings in June, July, August to review Sate Reportable incidents and compliance and all QA meetings thereafter Enter methods to evaluate for effectiveness: QA meetings will be held June, July, August for evaluation of State Report incidents and all QA meetings thereafter QA minutes will reflect evaluation of State Reports
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/1/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Ron Pierce **Date** Enter date of signature. 5/30/23

OAC 310:663-25-4(F)			
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@cardinalbay.org

July 28, 2023

License Number: AL1412

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

RE: Survey Event 851612

Dear Ms. Proctor:

On **July 25, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 11, 2023,** have now been corrected effective **July 1, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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-C 07/25/2023

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 conducted on 07/25/23. The facility was in substantial compliance.	{C 000}		

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