OKLAHOMA
State Department
of Health

Delivery via email to: jbyerly@midwest-health.com

October 24, 2024

License Number: AL2002

Ms. Julie Byerly, Interim Administrator
Homestead Of Clinton
3200 West Hayes
Clinton, OK 73601

Survey Event ID: CE0E11

Dear Ms. Byerly:

On **October 15, 2024,** 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 Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action will be completed for each violation; and
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face to face, or a virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Homestead of Clinton**
Address: **3200 West Hayes**
City, State, Zip: **Clinton, OK., 73601**
Provider #: **AL2002**
Complaint #: **OK00064708**
Investigation Date(s): **10/14/24 through 10/15/24**

ALLEGATION(S)
1. The center failed to have and/or implement an effective pharmacy procedure to ensure medications were labeled.
2. The center failed to ensure assistance with activities of daily living was provided in a timely manner and according to the contract and the plan of care.
3. The center failed to have call lights available to ensure residents the ability to communicate their needs with the nursing staff and failed to ensure a comfortable environment by utilizing proper repositioning techniques according to the standard of care.
4. The center failed to ensure competent and adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 10/14/2023 at 2:30 p.m.

A sample of four 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 on and throughout the survey. Resident records were reviewed including licenses, grievances, incident reports, care plans, orders, progress notes, call light report logs, ADL task sheets and medication administration records. Staffing schedules and records were reviewed. Residents, staff members, and family representatives were interviewed and asked about quality of care, medication administration, call light response times, and abuse concerns. Observations were made of medication administration, transfer assist, medication storage, staffing levels, call light response times and resident care.

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

OKLAHOMA
State Department
of Health

Date report completed: 10/18/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Homestead of Clinton**
Address: **3200 West Hayes**
City, State, Zip: **Clinton, OK., 73601**
Provider #: **AL2002**
Complaint #: **OK00067828**
Investigation Date(s): **10/14/24 through 10/15/24**

ALLEGATION(S)
1. The facility failed to ensure resident's were free from verbal, psychosocial abuse and neglect.
2. The facility failed to ensure sufficient staff to meet the needs of the residents and to ensure competent staff to administer medications.

An unannounced on-site investigation was initiated 10/14/2023 at 2:30 p.m.

A sample of four 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 on and throughout the survey. Resident records were reviewed including licenses, grievances, incident reports, care plans, orders, progress notes, and medication administration records. Staffing schedules and records were reviewed. Residents, staff members, and family representatives were interviewed and asked about quality of care, medication administration, and abuse concerns. Observations were made of medication administration, medication storage, staffing levels, and resident care.

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: 10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2002	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CLINTON	3200 WEST HAYES CLINTON, OK 73601

(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 Complaint investigations (#OK00067828 and OK00064708) were conducted on 10/14/24 and 10/15/24. Facility Census: 24 The following abreviations will be used throughout this document. AL - Assisted Living DON - Director of Nursing	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 incapacitated.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2002	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CLINTON	3200 WEST HAYES CLINTON, OK 73601

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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the center failed to follow standards of care and to implement interventions after a fall for two (#1 and #3) of three residents who were reviewed for interventions after a fall.

The Administrator identified 30 residents resided in the facility.

Findings:

The centers policy statement "Policy for Resident Falls and the Management of Residents Who Are At Risk for Fall", undated, read in part, "the community does maintain a process to assess residents for the risk of a fall and to implement prevention strategies for those identified as a fall risk."

1. The centers electronic health record "face sheet", documented Resident #1 was admitted on 06/01/19 with diagnoses which included dementia, cerebral infarction, and anxiety.

The centers "Oklahoma Recommended AL Resident Assessment" document, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2002	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CLINTON	3200 WEST HAYES CLINTON, OK 73601

(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 2 08/16/24, documented, Resident #1 was forgetful and required standby by assist with a walker and gait belt while ambulating for safety. The centers' "#223 Fall", incident report, dated 05/01/24, documented Resident #1 fell in the shower and had no injury. The incident report documented wet floor was the predisposing environmental factor causing the fall. The centers' "#223 Fall", incident report, dated 07/03/24, documented Resident #1 was trying to stand and hit the wrong button on their electric chair and slid onto the floor. The centers' "#223 fall", incident report, dated 09/23/24, documented Resident #1 fell while in the bathroom unobserved. The incident report documented Resident #1 was confused as a predisposing psychological factor contributing to the fall. The centers' "Service Plan", dated 07/05/24, reviewed for Resident #1 did not document interventions were added to prevent falls after the incidents on 05/01/24, 07/03/24, and 09/23/24. On 10/14/24 at 03:13 p.m., a family representative stated Resident #1 keeps falling and the center does not seem to be able to prevent the falls. On 10/15/24 at 11:04 a.m., the DON stated that after a fall, the policy would be to add interventions to the service plan. The DON reviewed the centers service plan for Resident #1. The DON stated there were no interventions added to the service plan and the facility policy was not followed.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2002	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CLINTON	3200 WEST HAYES CLINTON, OK 73601

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C1505	Continued From page 3 2. The centers' electronic health record "face sheet", documented Resident #3 was admitted on 12/22/20 with diagnoses which included dementia, anxiety, and stage 4 chronic kidney disease. The centers' "Oklahoma Recommended AL Resident Assessment", dated 10/01/24, documented Resident # 3 had intermittent confusion causing poor judgement, needs assistance with transfers, unsteady gait, and ambulates with a wheel chair. The centers' "#223 fall", incident report, dated 04/07/24, documented Resident #3 fell in their room without injury. The incident report documented confused and incontinent as predisposing factors contributing to the fall. The centers' "#223 fall", incident report, dated 05/24/24, documented Resident #3 was found on the floor in front of their recliner. No predisposing factors were documented in the incident report. The centers' "#223 fall", incident report, dated 09/08/24, documented Resident #e was found on the floor in front of their recliner. The incident report documented furniture, confused, drowsy, incontinent, and gait imbalance a predisposing factors contributing to the fall. The centers' "service plan", dated 06/19/23 was reviewed in the electronic health record. The service plan did not document interventions were added after the falls on 04/07/24, 05/24/24, and 09/08/24 to prevent future falls. On 10/15/24 at 3:25 p.m. the DON stated Resident #3 had three falls and no interventions were added to the service plan to prevent future	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2002	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CLINTON	3200 WEST HAYES CLINTON, OK 73601

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C1505	Continued From page 4 falls.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: jbyerly@midwest-health.com

November 19, 2024

License Number: AL2002

Julie Byerly, Administrator
Homestead Of Clinton
3200 West Hayes
Clinton, OK 73601

Survey Event ID: CE0E11

Dear Ms. Byerly:

On **October 15, 2024,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and 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 **November 1, 2024**.

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,

Lisa Calvin

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

Enclosure

Homestead of Clinton
3200 W. Hayes Ave.
Clinton, OK 73601
PH: (580) 323-0990
FAX: 1-855-478-0878

HOMESTEAD
ASSISTED LIVING
& MEMORY CARE
A Member of the Midwest Health Family

Fax

Subject:	Clinton POC
Date:	10/28/24

To:	OSDH	From:	Clinton Homestead
Phone number:		Phone number:	
Fax Number:	866-239-7553	No. of pages:	3

Comments:

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** 11-19-24 **Facility Name:** Homestead of Clinton **License Number:** AL2002 **Survey Event ID:** LCE011 **Date Survey Completed:** 10-15-24

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: record review and interview, the centerfailed to follow standards of care and to implement interventions after a fall for two (#1and #3) of three residents who were reviewed for interventions after a fall.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	a. The care plan will be updated with interventions post falls. Implemented on 11/1 and ongoing. Staff will be educated to report any s/s for 72 hours post fall and on care plan interventions by 11/1. b. Audit of compliance will be conducted monthly to determine compliance with care plan review and upate as appropriate r/t falls and interventions beginning 11/1 and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Every fall will be addressed in the same manner as stated above. Audit of compliance will be conducted by 11/1 and will continue on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The resident care coordinator will ensure that the monitoring of fall reporting, documentation and care plan updates occur for every fall. Implemented on 11/1 and ongoing. Staff will be educated on importance of reporting to the nurse in a timely manner. Completed by 10/30. The regional RN and float LPN will monitor compliance with random audits. Implement on 11/1 and ongoing. Resident care coordinator will report concerns to the regional RN. Implement on 11/1 and ongoing.
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;	The regional RN and float LPN will monitor compliance with random audits. Implement on 11/1 and ongoing. Resident care coordinator will report concerns to the regional RN. Implement on 11/1 and ongoing.

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.	a. Falls are trended to identify residents with falls and repeat falls. Implemented 11/1 and ongoing. Interventions will be evaluated for effectiveness for falls. Implement on 11/1 and ongoing. Audit of compliance will be conducted continue on a monthly basis. b. Falls are trended to identify residents with falls and repeat falls. Implemented 11/1 and ongoing. Interventions will be evaluated for effectiveness for falls. Implement on 11/1 and ongoing. Audit of compliance will be conducted continue on a monthly basis. c. Record of trending, effectiveness of interventions will be maintained in the QA binder. Implemented 11/1. Audit of compliance will be conducted continue on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/1/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Julie Bigsby	10/28/24

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.

* * * Communication Result Report (Oct. 28. 2024 4:14PM) * * *

1) Homestead of Clinton
2)

Date/Time: Oct. 28. 2024 4:13PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
0940	Memory TX	18662397553	P. 3	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size
E. 6) Destination does not support IP-Fax
E. 7) FAX Line is not connected

Comments:

To:	OSAH	From:	Clinton Homestead
Phone number:		Phone number:	
Fax Number:	844-239-7653	No. of pages:	3

Subject:	Clinton POC
Date:	10/28/24

Fax

Homestead of Clinton
2300 W. Hayes Ave.
Clinton, OK 73601
PH: (580) 323-0990
FAX: 1-855-478-0878

HOMESTEAD
ASSISTED LIVING & MEMORY CARE

OKLAHOMA
State Department of Health

Delivery via email to: Julie Byerly <jbyerly@midwest-health.com>

November 27, 2024

License Number: AL2002

Julie Byerly, Administrator
Homestead Of Clinton
3200 West Hayes
Clinton, OK 73601

Survey Event ID: CE0E12

Dear Ms. Byerly:

On **November 26, 2024,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 15, 2024,** have now been corrected effective **November 1, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2002	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CLINTON	3200 WEST HAYES CLINTON, OK 73601

(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 11/26/24. 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