OKLAHOMA
State Department
of Health

Delivery via email to: RobMar2@brookdale.com

November 5, 2025

License Number: AL2601

Mr. Robert Marchbanks, Administrator
Brookdale Chickasha
801 Country Club Road
Chickasha, OK 73018

RE: Survey Event ID: FFWY11

Dear Mr. Marchbanks:

On **October 28, 2025**, agents from our office concluded a State Licensure survey with complaint investigation 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 **October 28, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

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

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

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

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

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

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

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 OSDH.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: **Brookdale Chickasha**
Address: **801 Country Club Road,**
City, State, Zip: **Chickasha, OK 73018**
Facility ID: **AL2601**
Complaint #: **OK00075879**
Investigation Date(s): **10-27-25 and 10-28-25**

ALLEGATION(S)
The facility failed to ensure staff were qualified to administer medications.

An unannounced on-site investigation was initiated 10/26/2025 at 9:45 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the 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. Medication pass was observed.

Resident records including assessments, care plans, physician orders, reviewed. Grievance reports and state reportable records were reviewed. The facility completed investigation was reviewed.

Residents were interviewed regarding the care they receive and if they felt safe in the facility. Staff members were interviewed regarding the procedures for medication administration.

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: 10/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHICKASHA	801 COUNTRY CLUB ROAD CHICKASHA, OK 73018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey with complaint (#OK00075879) was conducted from 10/27/25 through 10/28/25. Deficiencies were cited as a result of the survey. Facility Census: 30 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide DON - director of nursing ED- executive director LPN - licensed practical nurse	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview the center failed to maintain infection control in the kitchen for one of one observations of the kitchen. The ED identified 30 residents resided in the center, and all 30 residents ate from the kitchen. Findings: On 10/27/25 at 10:46 a.m., the cook was	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHICKASHA	801 COUNTRY CLUB ROAD CHICKASHA, OK 73018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 391	Continued From page 1 observed cutting potatoes without gloves on. They were wearing a baseball cap but their hair was outside of the baseball cap. On 10/27/25 at 10:49 a.m., the cook was observed wearing gloves and with their hair tucked into their hat. The cook unlocked the door for surveyor to enter the kitchen through the door off of the dining room that had access to the hair nets and handwashing station. On 10/27/25 at 10:54 a.m., 3 Styrofoam cups with white substance with red substance over top was observed in the freezer uncovered with no label or date. A large bowl was observed covered with saran wrap that appeared to be ice cream that had started to melt and then was refrozen. There was no label or date. A blue bag was observed tied in a knot with no label or date. On 10/27/25 at 10:58 a.m., a box containing Ben's original long grain rice, was observed to be torn open with no label or date. A facility policy "Storage of Perishable Food," dated 5/10/05, read in part, "All pre-dished items must be covered, labeled, and dated." An undated "Employee hygiene" procedure document, read in part, "Employees must keep hair from contacting exposed food, clean equipment, utensils, and linens. Exposed hair must be covered with hairnet, hat, etc." On 10/27/25 at 10:53 a.m., the cook was asked about the Styrofoam cup in the refrigerator with a yellow substance in it with no label or date. The cook stated, "I have no idea," and then threw it away.	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHICKASHA	801 COUNTRY CLUB ROAD CHICKASHA, OK 73018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 391	Continued From page 2 On 10/27/25 at 10:54 a.m., the cook stated the cups were premade ice cream sundaes and vanilla ice cream was in the bowl. The cook then took them out of the freezer and threw them away. The cook stated the blue bag was was green beans that were going to be cooked that day. On 10/27/25 at 10:58 a.m., the cook stated the box was torn open and it looked like somebody had only cooked part of it. They stated it should have been sealed, labeled and dated. The cook took the box and threw it away. On 10/27/25 at 11:10 a.m., the cook was asked if they were wearing gloves earlier when they were cutting the potatoes and if their hair was secured to keep it from getting into the food. The cook stated they did not have gloves on because they were not the right size and they had just finished peeling the potatoes and did not want to cut themselves. They stated their hair was not secured as well as it should have been underneath the ball cap.	C 391		
C 922 SS=D	310:663-9-2(b) MEDICATION STAFFING (b) Unlicensed personnel administering medications shall have completed a training program that has been reviewed and approved by the Department. This Rule is not met as evidenced by: Based on record review and interview, the center	C 922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHICKASHA	801 COUNTRY CLUB ROAD CHICKASHA, OK 73018

(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 922	Continued From page 3 failed to ensure qualified staff administered medication to the residents. The ED identified 30 residents resided in the center. Findings: A typed statement, dated 01/14/25, showed Resident #9 stated there was a person that did not work there that did sometimes give them their medications. The statement was signed by the ED and DON. A typed statement, dated 01/14/25, showed CMA #1 admitted to giving Resident #9's medications to the ex-employee who then gave them to Resident #9. The statement was signed by the ED and DON. A typed statement, dated 01/15/25, showed an ex-employee admitted to placing a residents cup of medications on their bedside table. The statement was signed by the ED and DON. On 10/28/25 at 11:05 a.m., the ED stated CMA #1 had not worked there in a long time and the person passing out the medications was an ex-employee. They stated CMA #1 was suspended during the investigation.	C 922		

OKLAHOMA
State Department of Health

Delivery via email to: RobMar2@brookdale.com

November 19, 2025

License Number: AL2601

Mr. Robert Marchbanks, Administrator
Brookdale Chickasha
801 Country Club Road
Chickasha, OK 73018

RE: Survey Event FFWY11

Dear Mr Marchbanks:

On **October 28, 2025**, a Licensure inspection with complaint was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and 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 **December 1, 2025**.

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/11/2025** **Facility Name:** Brookdale Chickasha **License Number:** AL2601 **Survey Event ID:** FFWY11 **Date Survey Completed: 10/28/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: Based on observation, record review, and interview the center failed to maintain infection control in the kitchen for one of one observations of the kitchen.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Chickasha regarding the Statement of Deficienies dated 10/28/2025. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

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?	Food that was not stored, dated and labeled correctly was discarded on 10/27/2025. Dietary staff inserviced on proper securement of hair to prevent contact with food and proper procedure for use of gloves.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
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?	Executive Director will in-service dining associates on the following policies: Storage of Perishable Food – DS-04.013, Labeling – DS-04.028, Hair Restraints – DS-04.004 and Use of Gloves – DS-03.006. Dining Services Coordinator or designee will audit the food storage weekly to ensure food is stored, dated and labeled correctly each week for 6 weeks. Dining Services Coordinator or designee will audit hair securement and glove usage weekly to ensure compliance each week for 6 weeks.
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.	ED will audit weekly for compliance with labeling, dating and storage of food, hair restraint usage and glove usage. ED or designee will monitor weekly for compliance for 6 weeks. Monitoring results will be reviewed at QA meetings monthly for 3 months. Monitoring will be documented and signed by ED or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/1/2025

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.		**Date 11/17/2025**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/17/2025** **Facility Name:** Brookdale Senior Living **License Number:** AL2601 **Survey Event ID:** FFWY11 **Date Survey Completed: 10/28/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C922	Based on: Based on record review and interview, the center failed to ensure qualified staff administered medication to the residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Chickasha regarding the Statement of Deficienies dated 10/28/2025. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

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?	Center failed to follow the medication staffing policy on licensed personnel administering medications. A current associate allowed a previous co-worker at center to administer medication to a resident without the ED or HWD being aware of this violation. This occurred after management had left for the day. No known injury or harm came to this resident, but policy and procedures with center was not followed. An investigation was conducted, state reportable was timely reported and current employee was terminated.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents at the center had the potential to be affected but none were identified.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Medications associates will be re-inserviced on unlicensed personnel adminstering medcations being against state regulations and policy and procedures. Random audits of licensure will be conducted by ED, HWD or designee. Current medication staff are aware of the violation of administering medication without an approved license by state health dept.
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.	HWD or designee will monitor compliance through random audits of medication licensure and periodic medication inservices on unlicensed personnel administering medications. HWD or designee will monitor monthly for compliance for 3 months. Monitoring results will be reviewed at QA meetings monthly for 3 months. Monitoring will be documented and signed by HWD or designee.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?	11/17/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. E.D. OAC 310:663-25-4(F)	**Date 11/17/2025**

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

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

Items Below Are For OSDH Use Only

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

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

OKLAHOMA
State Department of Health

Delivery via email to: RobMar2@brookdale.com

December 8, 2025

License Number: AL2601

Mr. Robert Marchbanks, Administrator
Brookdale Chickasha
801 Country Club Road
Chickasha, OK 73018

RE: Survey Event FFWY12

Dear Mr. Marchbanks:

On **December 8, 2025,** 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 with complaints on **October 28, 2025,** have now been corrected effective **December 1, 2025.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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
	AL2601	A. BUILDING: _____ B. WING _____	R-C 12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHICKASHA	801 COUNTRY CLUB ROAD CHICKASHA, OK 73018

(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 12/08/25. 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