OKLAHOMA
State Department
of Health

Delivery via email to: loveparkview@gmail.com

November 2, 2022

License Number: AL3001

Ms. Janet Love, Administrator
Parkview Pointe Senior Living
721 Southwest 2nd Street
Laverne, OK 73848

RE: Survey Event ID: WT9U11

Dear Ms. Love:

On **October 27, 2022**, 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 **October 27, 2022**.

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 Digitally signed by Katie Stagner Date: 2022.11.02 16:44:20 -05'00'

Katie Stagner, Enforcement 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
	AL3001	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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
N 000	Initial Comments A relicensure survey was conducted on 10/26/22 and 10/27/22. The following abbreviations may have been used in the writing of this report. Approx.-approximately asst-assist b/p-blood pressure CLIA-Clinical Laboratory Improvement Amendments CNA-Certified Nursing Assistant cont.-continue ER-Emergency Room et-and lg-large POA-Power of Attorney P&P-Policy and Procedure PT/INR-Prothrombin Time/International Normalized Ratio Res-Resident MAT-Medication Administration Technician RM-Room RN-Registered Nurse	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long	N1105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3001	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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
N1105	Continued From page 1 term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure direct care staff completed two hours of monthly inservice's for six (CMA #1, CMA #2, MAT #1, #2, #3, #4) of seven staff reviewed for monthly inservice's and provide two hours inservice monthly for all staff. Findings: A review of the staff in-services contained no documentation the facility had completed them for December 2021, April 2022 and May 2022. A staff roster, provided by the Administrator, dated 10/26/22, documented CMA #1, CMA #2 and MAT #1, #2, #3 and #4 as current employees. An undated, form titled, "[Facility Name] Inservice September 2022", documented MAT #2, Mat #4 and CMA #1 "did not work". On 10/27/22 at 9:06 a.m., staff inservice's were reviewed with RN #1. RN #1 was asked if MAT #2, Mat #4 and CMA #1 had attended the inservice for the month of September 2022. RN #1 acknowledged the three staff identified had no	N1105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3001	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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
N1105	Continued From page 2 inservice for the month. RN #1 was asked if there was any documentation staff monthly inservice's had been completed for December 2021, April 2022 and May 2022. They stated, "I don't see them."	N1105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3001	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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 on 10/26/22 and 10/27/22. The following abbreviations may have been used in the writing of this report. Approx.-approximately asst-assist b/p-blood pressure CLIA-Clinical Laboratory Improvement Amendments CNA-Certified Nursing Assistant cont.-continue ER-Emergency Room et-and lg-large POA-Power of Attorney P&P-Policy and Procedure PT/INR-Prothrombin Time/International Normalized Ratio Res-Resident MAT-Medication Administration Technician RM-Room RN-Registered Nurse	C 000		
C1505 SS=D	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	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3001	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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 1 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview the center failed to: a. ensure a resident with elevated b/p and a nose bleed was monitored for one (#6) of six sampled residents reviewed for a change in condition, and b. obtain a CLIA waiver prior to providing point of care testing (PT/INR) for one (#5) of one sampled resident reviewed for point of care testing. Findings:	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3001	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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 An undated P&P, "Monitoring/Observation By Staff", read in parts, "...Staff shall monitor for changes in the status of residents and report and document such changes according to established procedures and in a timely manner...Document any intervention in the resident's Service Notes, along with any follow -up action taken. Continue documentation until resolution of the concern is noted..." 1. Res #6 had diagnoses which included, high blood pressure and arthritis. A preadmission assessment, dated 05/16/22, documented the resident was alert and oriented, forgetful, with fair judgement. A "Service Note", dated 05/27/22 at 8:13 a.m. read in parts, "...Resident...was at dining table [with] a nosebleed. I tried putting pressure on nose to get it to stop bleed to no avail...Res started spitting up lg. blood clots..." Family was notified and declined to send Res #5 to the hospital for evaluation. "...Blood pressure checked 177/111 P 113 T 97.7. I asst. Res. to room and [the resident] said, "I feel a bit light headed."...Resident is in RM in recliner resting. Will cont. to monitor..." Service Note was documented by a CNA/MAT. A "Service Note", dated 05/27/22 at 12:15 p.m., read in parts, "Res. had another nose bleed at lunch table...Lasted Approx. 20 minutes. Res. POA was called et said to send to [name] ER by ambulance..." Service Note was documented by a CNA/MAT. There was no documentation Res #6 had been assessed/reevaluated from 8:15 a.m. through 12:15 p.m.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3001	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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 An emergency room "Provider Note", dated 05/27/22 at 1:39 p.m., read in parts, "Chief Complaint...Bloody nose 2 today...Patient reports that earlier this morning [the resident] did have a dull headache, but this has since resolved... [family member] reported that [the residents] blood pressure has been running more elevated than usual it was relatively elevated at the clinic the other day...Physical Exam...B/P 200/108...P 101..." On 10/27/22 at 9:29 a.m., the RN was asked to review Res #6's service notes. The RN was asked if the resident had been monitored, with a B/P 177/111 and pulse 113 and complaints of feeling light headed. The RN reviewed the service notes and stated there was no documentation the resident had been monitored. The RN stated, it may be in the communication notes. The RN checked the communication notes and stated, there was no documentation. 2. Res #1 had diagnoses which included, hypertension, atrial fibrillation and chronic kidney disease. A form titled "[Facility name] Physician Telephone orders", documented the center obtained a PT/INR for Res #1 on 09/20/22, 09/27/22, 10/04/22, 10/11/22 and 10/18/22. A physicians order, dated October 2022, read in parts, "...Monthly INR's..." On 10/27/22 at 8:30 a.m., Res #1 was asked how often was a PT/INR level checked. They stated, on Tuesdays. Res #1 was asked who does the PT/INR. They stated, [RN#1].	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3001	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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 4 On 10/27/22 at 9:14 a.m., RN #1 was asked who is completing the PT/INR for Res #1. They stated, I am doing it. RN #1 was asked how often. They stated weekly. On 10/27/22 at 11:02 a.m., RN #1 was asked if there was an order for weekly PT/INR checks. They stated, no the orders still say monthly. On 10/27/22 at 2:39 p.m., the Administrator was asked if the center had a CLIA waiver or a policy and procedure for point of care testing. They stated, "No."	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: loveparkview@gmail.com

November 18, 2022

License Number: AL3001

Ms. Janet Love, Administrator
Parkview Pointe Senior Living
721 Southwest 2nd Street
Laverne, OK 73848

RE: Survey Event WT9U11

Dear Ms. Love:

On **October 27, 2022,** agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **Tag C1505 -** The Plan of Correction does not address how often the skilled nurse will monitor and record findings from review of the medical record, and if these findings will be reported to QA.

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

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
Date: 2022.11.18 10:42:05 -06'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

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: 11/15/2022** **Facility Name:** Parkview Pointe Senior Living **License Number:** AL3001 **Survey Event ID:** WT9U11 **Date Survey Completed: 10/27/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1105	Based on: The Center failed to ensure 2 hours of monthly inservice.

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?	Updated Employee Handbook to inform certified staff is required to perform inservice whether scheduled to work or not.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents were not directly effected by this deficiency.
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?	A signature is required by employee for proof of inservice training, whether scheduled to work or not
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.	Licensed staff will ensure certified staff completes month inservice. Will be discussed quarterly in Q & A meeting. Enter methods to incorporate into QA system: Testing and signatures will be placed in the survey manual when completed. Licensed staff will ensure all certified staff is accountable whether working or not.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/1/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 11/15/2022**

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.

EMPLOYEE HANDBOOK

Revised November 2022

EMPLOYMENT OVERVIEW

Introductory Period and Orientation

Each employee of Parkview Pointe Senior Living is hired for an introductory period of 60 days, to provide both an opportunity to evaluate the interest in the job and ability to perform the assigned tasks.

During this introductory period, you will be provided with orientation and training so that you gain a clear understanding of your job assignment and responsibilities. If at any time you have questions regarding your position, job responsibilities, or Parkview Pointe's policies and procedures, please do not hesitate to ask your supervisor or Administrator.

During your introductory period, your job performance will be closely monitored. If at any time your work is unsatisfactory or you don't appear to be well-suited to your position, your status will be reviewed with you by your supervisor.

Completion of the introductory period does not entitle you to remain employed by Parkview Pointe for any definite period. Both are free to terminate the employment relationship, at any time, with or without notice and for any reason not prohibited by law.

Job Descriptions

Job descriptions are given to each employee at the time of hire. Employees are expected to meet all the expectations and responsibilities outlined in their job descriptions on a consistent basis.

Training

Employees are required to participate and complete educational programs for upkeep of a professional license, certification, or designation and/or competency for their position. Two hours of in-service training will be required for certified nursing staff (CNAs and CMAs) every month. This training is required even if the certified nurse is not scheduled to work during the month.

Performance Evaluations

Employees receive an evaluation of their performance after one year of employment by their supervisor and repeated each year at a date that is convenient for both employee and supervisor. The evaluation will consider your performance, attitude, and knowledge of your duties. Your supervisor will evaluate the quality of your work and will discuss with you how well you are carrying out the duties of your job, with suggestions made as to where and how improvements can be implemented. We also encourage you to make suggestions for possible improvements in the efficiency or effectiveness of your position.

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/15/2022
Facility Name: Parkview Pointe Senior Living
License Number: AL3001
Survey Event ID: WT9U11
Date Survey Completed: 10/27/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: (a) ensure resident with elevated bp was monitored for change of condition

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Inservice training on documentation to certified staff has been completed and policy revised to indicate what "will monitor" requires of staff.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Policy has been revised to define actions/requirements of certified staff for "will monitor".
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?	If a resident requires charting of monitoring, policy has been updated to define what monitoring will require to include vital signs and times and licensed staff notification
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.	Enter methods to ensure corrections are sustained: Residents will be evaluated at least every 30 minutes for an hour. Staff will notify licensed staff for further advisement. Inservice at least yearly on documentation Licensed on call staff will review medical record
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/1/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Janet Rose	**Date 11/15/2022**

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.

PARKVIEW POINTE
SENIOR LIVING

HEALTH SERVICES MANUAL

Updated November 2022

4. If a medication is given to the wrong resident, the staff person who made the error should document the error on the medication record for the resident to whom the wrong medication was given. The information recorded should include the date, time, medication given, "Med Error" and a description of the error, any action taken and any additional comments. The staff person should then initial on the back of the record.

5. The staff member involved in the medication error should also complete a Medication Error Incident Report.

   - On a Medication Error Incident Report form, describe the incident, note all action taken, and sign the form. Under the "Action Taken" part of the form, document all individuals contacted regarding the incident (e.g., physician, family, licensing agency, etc.).

   - The RN and/or Nurse Coordinator should note any additional action needed. Develop a plan to prevent recurrence of the incident. The RN, Nurse Coordinator and Administrator should review and sign the Medication Error Incident Report form.

6. Document the original incident and all follow-up action taken in the resident's Service Notes (this can be a summary of the incident with a reference to the Medication Error Incident Report).

7. Provide appropriate follow-up and training to the staff person who made the medication error (with disciplinary action taken if needed). Document all action taken in the employee's Personnel Notes.

MONITORING / OBSERVATION BY STAFF

POLICY: Staff shall monitor for changes in the status of residents and report and document such changes according to established procedures and in a timely manner.

PROCEDURES:

1. All employees should, on an ongoing basis, observe for changes in the status of residents. Train staff on the types of changes to look for and reinforce that monitoring is the responsibility of ALL employees – not just those providing personal care or health-related services.

2. Examples of changes that staff may observe include:

   - Increased swelling in the ankles, fingers, feet and/or hands

   - Rashes, bruising, skin tears, or a change in the condition or color of the skin

   - A change in appetite, fluid intake, or weight loss/gain

- A change in mood, emotion, or daily habits
- A change in sleeping patterns
- A change in the color, odor, and/or consistency of urine or bowel movements
- A change in the resident's normal temperature, pulse, or blood pressure.

3. Staff should report any changes to the RN and/or Nurse Coordinator and document them in the resident's Service Notes. When staff report changes in a resident's condition to the RN or Nurse Coordinator he/she must determine what action should be taken. Interventions that might be appropriate include:

Added

- Rechecking vital signs at least every 30 minutes for 1 hour. If vital signs remain askew staff will notify supervisor for further advisement.
- Assisting the resident with administration of a PRN medication.
- Continued observation / monitoring by staff.
- Additional evaluation by the RN and/or Nurse Coordinator.
- Informing the resident's physician of the concern and following any instructions provided by him/her.
- Scheduling an appointment for the resident with his/her physician.
- Calling 911 for emergency assistance if needed.

4. Document any intervention taken in the resident's Service Notes, along with any follow-up action taken. Continue documentation until resolution of the concern is noted.

ROUTINE MONITORING OF VITAL SIGNS

POLICY: Take vital signs on a weekly basis or more frequently if ordered by a resident's physician and document results according to established procedures.

PROCEDURES:

1. Vital signs will be taken on a weekly basis, to establish a baseline for the resident's health condition. This enables the RN and/or Nurse Coordinator and/or the resident's physician to detect deviations from this baseline and to be proactive in the resident's healthcare.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/15/2022** **Facility Name:** Parkview Pointe Senior Living **License Number:** AL3001 **Survey Event ID:** WT9U11 **Date Survey Completed: 10/27/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: (b) Obtain a CLIA waiver prior to providing point of care testing

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?	CLIA waiver application has been accepted and approved as of November 14, 2022. Which will be used for INR home testing.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Waiver will allow additional testing for INR home testing.
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?	Waiver will be kept up to date.
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.	Enter methods to ensure corrections are sustained: Testing will be completed as required by third party & physician orders. Licensed staff will complete. Waiver was required. Application has been accepted and approved. Waiver will be kept current.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/14/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Janet Rae	**Date 11/15/2022**	

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.

Gmail

Jan Love <loveparkview@gmail.com>

Parkview Pointe Sr. Living - CLIA application approved

1 message

Diana L Wheatley <DianaLW@health.ok.gov>
To: Jan Love <loveparkview@gmail.com>
Cc: OSDH CLIA <CLIA@health.ok.gov>

Mon, Nov 14, 2022 at 11:54 AM

Jan,

Your CLIA application has been accepted and approved. CMS will send a fee coupon (CMS's version of an invoice) to the address designated on your application, once the fees are paid your CLIA certificate will be mailed and should arrive within 2-3 weeks. Patient testing may begin once the laboratory has received the CLIA certificate in the mail.

You can request a duplicate fee coupon (invoice) to be emailed to you, which can allow you to pay the invoice sooner. Please respond to this email and ask for a duplicate invoice to be emailed to you. CMS only updates their database once a week (Tuesday night), therefore the invoice cannot be generated until the Wednesday after this acceptance email.

Attached is an informational booklet written by the CDC to assist you with testing procedures. Contact our office with any questions.

Diana Wheatley | CLIA Coordinator
Medical Facilities | Oklahoma State Department of Health
o. 405-426-8470 | d. 405-426-8467 | f. 405-900-7559
Oklahoma.gov/Health | Oklahoma.gov/COVID19

OKLAHOMA

Long Term Care

Oklahoma State
Department of Health

Assisted Living Optional Plan of Correction Form

Customer Feedback

Did you find the assisted living optional plan of correction form and instructions helpful?

Yes X

No

Did not use

What about the form or instructions did you find or not find helpful? It was helpful to use as a guide to answer your questions more thoroughly.

Please let us know if there is anything you would like to see changed or improved on the form or instructions. Some deficiencies only require one answer and proof of compliance. The other questions are unnecessary but to complete the form we must answer.

Please return with your plan of correction or fax to 405.271.2206 or email to LTC@health.ok.gov. Thank you for your feedback.

OKLAHOMA
State Department
of Health

Delivery via email to: loveparkview@gmail.com

November 30, 2022

License Number: AL3001

Ms. Janet Love, Administrator
Parkview Pointe Senior Living
721 Southwest 2nd Street
Laverne, OK 73848

RE: Survey Event WT9U11

Dear Ms. Love:

On **October 27, 2022**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your amended 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 **December 1, 2022**.

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

Digitally signed by Tempal Killman
Date: 2022.11.30 11:50:23 -06'00'

Tempal Killman, Administrative Assistant II
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: 11/15/2022** **Facility Name:** Parkview Pointe Senior Living **License Number:** AL3001 **Survey Event ID:** WT9U11 **Date Survey Completed: 10/27/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1105	Based on: The Center failed to ensure 2 hours of monthly inservice.

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?	Updated Employee Handbook to inform certified staff is required to perform inservice whether scheduled to work or not.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents were not directly effected by this deficiency.
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?	A signature is required by employee for proof of inservice training, whether scheduled to work or not
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.	Licensed staff will ensure certified staff completes month inservice. Will be discussed quarterly in Q & A meeting. Enter methods to incorporate into QA system: Testing and signatures will be placed in the survey manual when completed. Licensed staff will ensure all certified staff is accountable whether working or not.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/1/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Janet Rose	**Date 11/15/2022**

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.

PARKVIEW POINTE

SENIOR LIVING

EMPLOYEE HANDBOOK

Revised November 2022

EMPLOYMENT OVERVIEW

Introductory Period and Orientation

Each employee of Parkview Pointe Senior Living is hired for an introductory period of 60 days, to provide both an opportunity to evaluate the interest in the job and ability to perform the assigned tasks.

During this introductory period, you will be provided with orientation and training so that you gain a clear understanding of your job assignment and responsibilities. If at any time you have questions regarding your position, job responsibilities, or Parkview Pointe's policies and procedures, please do not hesitate to ask your supervisor or Administrator.

During your introductory period, your job performance will be closely monitored. If at any time your work is unsatisfactory or you don't appear to be well-suited to your position, your status will be reviewed with you by your supervisor.

Completion of the introductory period does not entitle you to remain employed by Parkview Pointe for any definite period. Both are free to terminate the employment relationship, at any time, with or without notice and for any reason not prohibited by law.

Job Descriptions

Job descriptions are given to each employee at the time of hire. Employees are expected to meet all the expectations and responsibilities outlined in their job descriptions on a consistent basis.

Training

Employees are required to participate and complete educational programs for upkeep of a professional license, certification, or designation and/or competency for their position. Two hours of in-service training will be required for certified nursing staff (CNAs and CMAs) every month. This training is required even if the certified nurse is not scheduled to work during the month.

Performance Evaluations

Employees receive an evaluation of their performance after one year of employment by their supervisor and repeated each year at a date that is convenient for both employee and supervisor. The evaluation will consider your performance, attitude, and knowledge of your duties. Your supervisor will evaluate the quality of your work and will discuss with you how well you are carrying out the duties of your job, with suggestions made as to where and how improvements can be implemented. We also encourage you to make suggestions for possible improvements in the efficiency or effectiveness of your position.

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/18/2022
Facility Name: Parkview Pointe Senior Living
License Number: AL3001
Survey Event ID: WT9U11
Date Survey Completed: 10/27/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: (a) ensure resident with elevated bp was monitored for change of condition.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Inservice training on documentation to certified staff has been completed and policy revised to indicate what "will monitor" requires of staff.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Policy has been revised to define actions/requirements of certified staff for "will monitor".
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?	If a resident requires charting of monitoring, policy has been updated to define what monitoring will require to include vital signs and times and licensed staff notified.
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.	Enter methods to ensure corrections are sustained: Residents will be evaluated at least every 30 minutes for an hour. Staff will notify licensed staff for further advisement. Inservice training on documenting will be done yearly. All incidents requiring provider interventions reviewed quarterly in the Q&A meeting. Licensed on call staff will review medical record next working day.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/1/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Janet Love	**Date 11/18/2022**

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	11/18/2022	**Submitted by**	Janet Love, Admin

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.

- A change in mood, emotion, or daily habits
- A change in sleeping patterns
- A change in the color, odor, and/or consistency of urine or bowel movements
- A change in the resident's normal temperature, pulse, or blood pressure.

3. Staff should report any changes to the RN and/or Nurse Coordinator and document them in the resident's Service Notes. When staff report changes in a resident's condition to the RN or Nurse Coordinator he/she must determine what action should be taken. Interventions that might be appropriate include:

AMENDED

- Rechecking vital signs at least every 30 minutes for 1 hour. If vital signs remain askew staff will notify supervisor for further advisement. On call licensed staff will review medical record next working day for appropriate interventions.
- Assisting the resident with administration of a PRN medication.
- Continued observation / monitoring by staff.
- Additional evaluation by the RN and/or Nurse Coordinator.
- Informing the resident's physician of the concern and following any instructions provided by him/her.
- Scheduling an appointment for the resident with his/her physician.
- Calling 911 for emergency assistance if needed.

4. Document any intervention taken in the resident's Service Notes, along with any follow-up action taken. Continue documentation until resolution of the concern is noted.

ROUTINE MONITORING OF VITAL SIGNS

POLICY: Take vital signs on a weekly basis or more frequently if ordered by a resident's physician and document results according to established procedures.

PROCEDURES:

1. Vital signs will be taken on a weekly basis, to establish a baseline for the resident's health condition. This enables the RN and/or Nurse Coordinator and/or the resident's physician to detect deviations from this baseline and to be proactive in the resident's healthcare.

OKLAHOMA
State Department
of Health

Delivery via email to: loveparkview@gmail.com

January 19, 2023

License Number: AL3001

Ms. Janet Love, Administrator
Parkview Pointe Senior Living
721 Southwest 2nd Street
Laverne, OK 73848

RE: Survey Event WT9U12

Dear Ms. Love:

On **January 18, 2023,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 27.2022,** have now been corrected effective **December 1, 2022.**

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement 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
	AL3001	A. BUILDING: _____ B. WING _____	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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
{N 000}	Initial Comments A revisit was conducted on 01/18/23. All deficiencies from 10/27/22 were cleared.	{N 000}		

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

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3001	A. BUILDING: _____ B. WING _____	R 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POINTE SENIOR LIVING	721 SOUTHWEST 2ND STREET LAVERNE, OK 73848

(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 revisit was conducted on 01/18/23. All deficiencies from 10/27/22 were cleared.	{C 000}		

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