OKLAHOMA
State Department
of Health

Delivery via email to: hgt-ed@12oaks.net

January 31, 2024

License Number: AL5101

Ms. Carla Gay, Executive Director
Azalea Gardens Memory Care
3211 Chandler Road
Muskogee, OK 74403

Survey Event ID: RXTZ11

Dear Ms. Gay:

On **January 17, 2024,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your assisted living facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in the potential for no 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,

Tempal Killman

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Azalea Gardens Memory Care**
Address: **3211 Chandler Rd**
City, State, Zip: **Muskogee, OK, 74403**
Provider #: **AL5101**
Complaint #: **OK00062153**
Investigation Date(s): **01/16/24 and 01/17/24**

ALLEGATION(S)

The center failed to assess, monitor, and intervene in a timely manner for a change in condition.
The center failed to ensure residents were not physical, verbally, or psychosocially abused.
The center failed to notify residents' representatives of resident-to-resident abuse.
The center failed to ensure the Oklahoma State Department of Health was notified of a fall with major injury and resident-to-resident abuse within two hours.

An unannounced on-site investigation was initiated 01/16/2024 at 9:30 a.m.

A sample of three 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:

Tours of the center were conducted on entry and throughout the survey. Residents were observed in activities, dining, ambulating in the halls, and engaging in social activities in the family rooms. Staff were observed assessing, monitoring, and engaging with residents in a respectful manner. Family members were observed visiting and engaging with their loved ones and staff members.

Residents were interviewed, if able, and did not express concerns regarding abuse, neglect, falls, or family notification for a change in condition. Staff members were interviewed and expressed an understanding of the center's policies regarding abuse, neglect, falls, and resident changes in conditions. Family members were interviewed.

Resident records, including resident contracts, service agreements, physician orders, nurse notes, and emergency medical personnel documentation, were reviewed. Incident reports, including state reportable incidents and investigations, were reviewed. Policies and procedures were reviewed.

The attached Statement of Deficiencies, Form 2567 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: 01/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA GARDENS MEMORY CARE	3211 CHANDLER ROAD MUSKOGEE, OK 74403

(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 complaint investigation (#OK00062153) was conducted on 01/16/24 and 01/17/24. Facility Census: 34 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aide DHS - Department of Human Services ED - emergency department EMS - emergency medical services MAT - Medication Administration Aide ODH - Oklahoma Department of Health OSDH - Oklahoma State Department of Health RCD - resident care director Res - resident VA - Veterans Administration .	C 000		
C 381 SS=D	310:663-3-7(a) SERVICES SPECIFIC TO CONTINUUM OF CARE (a) Each continuum of care facility shall provide, coordinate or arrange care appropriate to the needs and capabilities of its residents. This Rule is not met as evidenced by: Based on record review and interview the center failed to ensure residents received appropriate assessment and care subsequent to an injury for one (#1) of three residents reviewed for	C 381		

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C 381	Continued From page 1	C 381		

assessment, monitoring, and intervention following an injury.

The executive director reported 34 residents were in the center at the time of the survey.

Findings:

The Oklahoma Board of Nursing, "Delegation of Nursing Functions to Unlicensed Persons", revised 03/28/23, read in part, ".... III. Policy: A... Unlicensed personnel may be used to complement the licensed nurse in the performance of nursing functions, but such personnel cannot be used as a substitute for the licensed nurse...F. Nursing Tasks That May Not Be Delegated: By way of example, and not in limitation, the following are nursing tasks that are not within the scope of sound nursing judgment to delegate: 1. Nursing tasks which require nursing assessment, judgment, evaluation and teaching during implementation; such as, a. physical, psychological, and social assessment which requires nursing judgment, intervention, referral or follow-up..."

A facility policy, titled "MONITORING/OBSERVATION BY STAFF", revised on 08/22/23, read in part, "POLICY: Staff shall monitor for changes in condition of Residents and report and document such changes according to established procedures and in a timely manner...3. Staff should report any changes to the Resident Care Director and document them in the Resident's Service Notes. When staff report changed in a Resident's condition to the Resident Care Director, he/she must determine what action should be taken. Interventions that might be appropriate include...additional evaluation by the Resident

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C 381	Continued From page 2 Care Director and/or other health care professional...Calling 911 for emergency assistance. 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." Res #1 was admitted to the center with diagnoses which vascular dementia, anxiety disorder, and psychotic disturbance. Res #1's progress notes did not contain any documentation after the date of 12/25/23. The local EMS did have documentation of a call out for Res #1 on 12/31/23 for transport to the hospital. A pre-hospital care report from the local EMS service, dated 01/01/24 at 3:39 a.m., documented Res #1 was transferred to the local VA hospital for altered mental status and vomiting and diarrhea. The form documented the EMS received report the resident had been found lying in their bed and had experienced nausea and vomiting. The form documented the staff cleaned the resident up and an hour later went to check on them again and the resident had placed themselves on the floor and had again experienced nausea and vomiting. The form documented the staff member had stated the resident was lethargic and difficult to arouse. The note documented the resident would only respond to pain and had dried blood around both nares. The noted documented the staff member advised EMS the blood was from an altercation with the roommate a few days ago in which the roommate broke the resident's nose. A pre-hospital care report from the local EMS	C 381		

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service, dated 01/01/24 at 5:41 a.m., documented Res #1 had been diagnosed with bilateral subdural hematomas by CT scan without contrast by the VA hospital. The EMS note documented the nurse stated the resident had been in an altercation with the roommate two days ago and had not been examined at the hospital after the incident. The note documented the resident was being sent to a higher level of care at another hospital for neurology and neurosurgery.

A state reportable incident form, submitted on 01/02/24, documented a resident to resident incident occurred on 12/21/23. The form documented Res #1 came out of their room with blood on their nose. The form documented Res #2 stated they hit Res #1. The form did not document the time the resident to resident incident occurred or the time Res #1 was observed with blood on their nose. The form did not document the resident had been sent to the hospital for altered mental status and nausea and vomiting. The form documented the resident had been sent to the VA and then to a hospital for a higher level of care related to a brain bleed. The form documented the resident was to have surgery related to the bleed. The form documented the wife and physician stated the hit did not cause the bleed but thought the bleed may have been going on for a while and could have been the cause of the recent increase in behaviors.

On 01/16/24 at 1:40 p.m., the resident care coordinator from a sister home stated the staff who were working at the time of the incident were most likely agency and they would attempt to find who was working.

On 01/16/24 at 2:28 p.m., CMA #1 stated they did

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not witness the resident to resident altercation during the early morning on 12/31/23. The CMA stated they contacted the RCD by phone and reported the incident. The CMA stated they were told not to send the resident out to be evaluated at the emergency room. The CMA stated they asked if the resident needed to have a mobile X-ray and were told by the RCD the mobile X-ray service would not be available until 01/02/24 due to the holiday. The CMA stated they worked the rest of the shift and kept Res #1 in the dining room with them. They stated they also worked the day shift on 12/31/23. The CMA stated they found out the resident had been sent to the hospital on 01/01/24 after that.

On 01/16/24 at 2:33 p.m., CNA #2 stated they saw Res #1 on the floor on 01/01/24 and CNA #1 was attempting to contact the executive director to get permission to send the resident to the hospital.

On 01/01/16 at 2:40 p.m., the executive director stated they had not been informed of the resident to resident altercation until the staff contacted them for permission to send the resident to the emergency room due to nausea and vomiting.

On 01/16/24 at 5:30 p.m., the RCD stated they were on call and the staff had sent a photo of the resident's nose and asked if they thought it was fractured. They were not in the facility at the time of the resident to resident incident due to illness and had instructed the staff to send the resident to the hospital for evaluation. They stated there were no other nurses to fill in when they were unable to be in the facility and there were only CNAs, CMAs, and MATs, on duty at the time of the incident. The RCD confirmed they had not presented to the facility to evaluate the resident

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C 381	Continued From page 5 after Res #1 was found bleeding from both nares. On 01/17/24 at 10:40 a.m., the RCD stated the facility had instructed them to not provide the text messages regarding the incident of the resident to resident and Res #1 bloody nose. The RCD stated they had been instructed by administration not to document reportable incidents in the resident notes. The RCD stated they did instruct the staff to send the resident to the ED when notified about their nose. They stated when they found out later the resident had not been sent, they again called and spoke with the person in house to send the resident to the ED but did not document the conversation. The RCD stated that they found out the resident had not been sent until 01/01/24 and stated the staff had not attempted to contact them and they were always available. The RCD was unable to provide any documentation for the text messages, phone calls, investigation of the resident to resident altercation, conversation with the resident's family, hospital records, or notes. On 01/17/24 at 12:15 p.m., the regional director stated they could not find any documentation of the incident or response other than the incident report. The regional director stated they started their own investigation of the resident to resident altercation and spoke to all the staff involved on 01/16/24. They stated the staff reported they were told to not send the resident out for evaluation of the injury to Res #1's nose and instead to obtain a mobile X-ray on 01/02/24 by the RCD. On 01/17/24 at 5:05 p.m., during the exit conference, the regional director stated the staff on duty at the time of the injury to Res #1's nose had texted the RCD but the RCD had not given	C 381		

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C 381	Continued From page 6 them instruction to send the resident to the ED and the staff kept the resident in sight to see if the resident's condition changed necessitating them to send the resident to the ED. The regional director stated the RCD was on call at all times, even if ill and not in the facility, and was able to determine the resident was stable and able to remain in the facility over the phone.	C 381		
C1304 SS=D	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide all services that are specified in the resident's service contract for one (#1) of three residents whose service contract was reviewed. The executive director identified 34 residents who	C1304		

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C1304	Continued From page 7	C1304		

were present in the facility at the time of the survey.

Findings:

A facility document, titled "Resident Admission Agreement", dated 11/01/23, read in part, "...6. SERVICES INCLUDED IN YOUR MONTHLY FEE...b. Intermittent or unscheduled nursing intervention...EXHIBIT 1 RESIDENT RIGHTS IN ASSISTED LIVING...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...RESIDENT HANDBOOK...Accidents/Injuries/Acute Illness In the event of accident, injury...we will decide for emergency care and/or transfer to an appropriate place for treatment, i.e., physician's office, clinic, hospital, etc...."

Res #1 was admitted to the center with diagnoses which vascular dementia, anxiety disorder, and psychotic disturbance.

Res #1's progress notes did not contain any documentation after the date of 12/25/23.

The local EMS did have documentation of a call out for Res #1 on 12/31/23 for transport to the hospital.

A pre-hospital care report from the local EMS service, dated 01/01/24 at 3:39 a.m., documented Res #1 was transferred to the local VA hospital for altered mental status and vomiting and diarrhea. The form documented the EMS received report the resident had been found lying in their bed and had experienced nausea and vomiting. The form documented the staff cleaned

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C1304	Continued From page 8	C1304		

the resident up and an hour later went to check on them again and the resident had placed themselves on the floor and had again experienced nausea and vomiting. The form documented the staff member had stated the resident was lethargic and difficult to arouse. The note documented the resident would only respond to pain and had dried blood around both nares. The noted documented the staff member advised EMS the blood was from an altercation with the roommate a few days ago in which the roommate broke the resident's nose.

On 01/16/24 at 2:28 p.m., CMA #1 stated they did not witness the resident to resident altercation during the early morning on 12/31/23. The CMA stated they contacted the RCD by phone and reported the incident. The CMA stated they were told not to send the resident out to be evaluated at the emergency room. The CMA stated they asked if the resident needed to have a mobile X-ray and were told by the RCD the mobile X-ray service would not be available until 01/02/24 due to the holiday. The CMA stated they worked the rest of the shift and kept Res #1 in the dining room with them. They stated they also worked the day shift on 12/31/23. The CMA stated they found out the resident had been sent to the hospital on 01/01/24 after that.

On 01/16/24 at 5:30 p.m., the RCD stated they were on call and the staff had sent a photo of the resident's nose and asked if they thought it was fractured. The RCD stated they were not in the facility at the time of the alleged resident to resident incident due to personal illness and had instructed the staff to send the resident to the hospital for evaluation. They stated there were no other nurses to fill in when they were unable to be in the facility and there were only CNAs,

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C1304	Continued From page 9 CMAs, and MATs, on duty at the time of the incident. The RCD confirmed they had not presented to the facility to evaluate the resident after Res #1 was found bleeding from both nares. The RCD stated there was not a treatment for a broken nose anyway. On 01/17/24 at 12:15 p.m., the regional director stated they could not find any documentation of the incident or response other than the incident report. The regional director stated they started their own investigation of the resident to resident altercation and spoke to all the staff involved on 01/16/24 after the survey had begun. They stated the staff reported they were told to not send the resident out for evaluation of the injury to Res #1's nose and instead to obtain a mobile xray on 01/02/24 by the RCD. The regional director confirmed since the cause of Res #1's injury to their nose was unwitnessed and Res #1 and Res #2 had significant dementia the assumption was a resident to resident altercation based on a statement made by Res #2 when asked if they had struck Res #1. The regional director stated there was no sure way to determine if this was what had happened or if injury to Res #1's nose had been caused by another type of injury. The regional director did not provide any documentation of who they spoke with or any additional documentation. On 01/17/24 at 5:05 p.m., during the exit conference, the regional director stated the staff on duty at the time of the injury to Res #1's nose had texted the RCD and the RCD had not given them instruction to send the resident to the ED. The regional director stated the staff kept the resident in sight to see if the resident's condition changed which might necessitate them to send the resident to the ED. The regional director	C1304		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1304	Continued From page 10 stated the RCD was on call at all times, even if ill and not in the facility, and was able to determine the resident was stable and able to remain in the facility over the phone.	C1304		
C1970 SS=D	310:663-19-4(a) POLICIES (a) Each assisted living center shall have a written policy statement that expressly prohibits the abuse or neglect of residents or misappropriation of resident property it serves. The policy shall include the facility's investigative procedures and actions to be taken when incidents of abuse or neglect of residents or misappropriation of resident's property occur. This Rule is not met as evidenced by: Based on record review and interview the center failed to follow their abuse policy for one (#1) of three residents sampled for abuse. The administrator identified two incidents of abuse and neglect which occurred since 11/01/23. Findings: A facility policy, titled "RESIDENT RIGHTS, ABUSE, NEGLECT, OR EXPLOITATION" revised 05/13/22, read in part, "...Community staff...must report the abuse, neglect, or exploitation to:...1. one of the following law enforcement agencies: A municipal law enforcement agency...or the	C1970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	C 01/17/2024

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C1970	Continued From page 11 sheriff's department of the county...3. The Community must immediately make an oral report to ODH form 283 of the alleged abuse, neglect, or exploitation and must investigate the allegation ...You must also file a report to Oklahoma Department of Health Adult Protective Services Division...9. The Executive Director (or his/her designee) should immediately to investigate the allegations. Speak with all involved parties, including all staff on duty at the time of the alleged abuse, neglect, ore exploitation occurred to determine. Document all conversations (witnesses may also be asked to put their writing). The final entry in Res #1's progress notes in the electric medical records was documented at 12/25/23. A combined initial and final incident report form documented Res #1 had exited his room and was observed with blood on their nose. The form documented Res #2 stated they struck Res #1. The form documented both residents had vascular dementia and Res #1 had been wandering more lately and was having angry outbursts that had become more frequent. The form did not document abuse had occurred, DHS had been notified, or that the local law enforcement had been notified. The form documented the incident occurred on 12/31/23 and had been sent to OSDH on 01/02/24. On 01/16/24 at 2:40 the executive director had not been informed of the incident until the next day when staff contacted them for permission to send Res #1 to the hospital. The executive director stated they did not know much about the incident and the RCD would know more.	C1970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	C 01/17/2024

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C1970	Continued From page 12 On 01/17/24 at 10:40 a.m., the RCD stated none of the information regarding the alleged incident between Res #1 and Res #2 had been turned in. The RCD stated they were not there during the incident and the only information they received was when they found a note on their desk on 01/02/24 asking for them to call the resident's representative. At that time, the RCD stated they could not provide any documentation on any investigation, internal incident report, root cause analysis, interviews, or medical records.	C1970		

OKLAHOMA
State Department of Health

Delivery via email to: hgt-ed@12oaks.net

March 29, 2024

License Number: AL5101

Ms. Carla Gay, Administrator
Azalea Gardens Memory Care
3211 Chandler Road
Muskogee, OK 74403

Survey Event ID: RXTZ12

Dear Ms. Gay:

On **March 22, 2024,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 17, 2024,** have now been corrected effective **March 11, 2024.**

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
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
	AL5101	A. BUILDING: _____ B. WING _____	R-C 03/22/2024

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 03/22/24. 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