OKLAHOMA
State Department
of Health

Delivery via email to: pabennett@moradalakehefner.com; albaggs@moradalakehefner.com

June 5, 2025

License Number: AL5507

Mr. Alex Baggs, Administrator
Morada Lake Hefner
7535 West Hefner Road
Oklahoma City, OK 73162

Survey Event ID: 67O611

Dear Mr. Baggs:

On **May 19, 2025**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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. 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 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
IDRCoordinator@health.ok.gov
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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Morada Lake Hefner
Address: 7535 West Hefner Road
City, State, Zip: OKC, OK 73162
Provider #: AL5507
Complaint #: OK00082024
Investigation Date(s): 05/16/25-05/19/25

ALLEGATION(S)
The center failed to ensure an injury of unknown origin was reported to the POA
The center failed to ensure the resident's POA was notified of a change in condition
The center failed to ensure a resident was not admitted above the level of care the center could provide
The center failed to ensure residents were not involuntary discharged without cause
enter text

An unannounced on-site investigation was initiated 05/16/2025 at 8:00 a.m.

A sample of 6 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: During an initial tour of the center residents were observed for signs of neglect and/or at a level of care above what the center could provide. Observations of residents were made and interviews were conducted with residents and family members. Records of resident assessments, health records, discharge notices were reviewed as well as records of communication from the center to families. Based on observations, record review and interview, the center was in compliance in relation to the allegations.

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: 05/19/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Morada Lake Hefner
Address: 7535 West Hefner Road
City, State, Zip: OKC, OK 73162
Provider #: AL5507
Complaint #: OK00082252
Investigation Date(s): 05/16/25-05/19/25

ALLEGATION(S)
The center failed to ensure adequate supervision to prevent an elopement
enter text
enter text
enter text

An unannounced on-site investigation was initiated 05/16/2025 at 8:00 a.m.

A sample of 6 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: An initial tour of the center was conducted and residents were observed for signs of neglect and inappropriate placement. Exit doors were observed to be locked and intact. Records of resident assessments, medical charts, and center policies were reviewed. Interviews were conducted with residents, staff, and family members. Based on observation, record review, and interview, it was determined the center failed to provide adequate supervision to prevent an elopement.

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: 05/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5507	A. BUILDING: _____ B. WING _____	C 05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAKE HEFNER	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

(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 survey (#OK00082024 and #OK00082252) was conducted 05/16/25 through 05/19/25. Deficiencies were cited as a result of the survey. Facility Census: 33 Listed below are abbreviations that will be used throughout this document: CMA - certified medication aide DON - director of nursing IJ - immediate jeopardy OSDH - Oklahoma State Department of Health	C 000		
C1512 SS=K	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the	C1512		

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C1512	Continued From page 1 use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 05/16/25, an immediate jeopardy situation was determined to exit when the center failed to	C1512		

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C1512	Continued From page 2 provide supervision and intervene for Resident #1 to prevent elopement. On 05/16/25 at 11:36 a.m., the OSDH was notified and verified the existence of the IJ situation. On 05/16/25 at 11:55 a.m., the administrator and DON were notified of the IJ situation related to the elopement of Resident #1. On 05/16/25 at 2:14 p.m., the DON submitted an acceptable plan of removal. The plan of removal, read in part, "Plan Of Removal: Lake Hefner, 5/16/25 1. A one-on-one sitter has been implemented for [Resident #1] 24-7 until the resident is removed from the facility. 2. DDRC [divisional director of resident care] inserviced DHW [director of health and wellness] on Elopement Policy on 05/16/25. 3. All staff were inserviced on 05/15/25 on Elopement. 4. Door locks were changed on 05/14/25 and only staff have code. The code will be changed monthly. 5. All residents will be re-assessed for elopement risk by 05/19/2025 by noon. 6. All staff will check all exit doors oncoming to shift and off going of shift." The IJ was removed on 05/19/25 at 12:00 p.m., when all components of the plan of removal had been verified as completed. Interviews conducted with staff and family verified Resident #1 had a one-on-one sitter from 05/16/25 through 05/19/25. A document titled, "Elopement In-service," dated 05/16/25 verified the DON had been educated on the elopement policy. All staff	C1512		

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C1512	Continued From page 3	C1512		

were in-serviced on elopement on 05/15/25 as verified through staff interviews and signatures shown on the inservice. Door locks were changed prior to initiation of the complaint survey. This was verified by a sign on the front door stating, "Ring bell. New code." An interview with CMA #1 verified the code was changed to all exit doors. Verification of re-assessment of resident elopement risk was provided in a document titled, "Resident Elopement Re-assessment," dated 05/16/25. Interviews with staff verified they were checking all exit doors at the beginning and end of shifts. The deficiency remained at a pattern level with a potential for more than minimal harm.

Based on observation, record review, and interview, the facility failed to provide supervision to prevent an elopement for 1 (#1) of 6 residents sampled for elopement.

The administrator identified 33 residents resided in the center.

Findings:

On 05/16/25 at 8:34 a.m., Resident #1 was observed lying in their bed in their apartment. The resident's apartment was approximately 15 feet from the Southeast door they eloped from.

A "14-day Comprehensive Assessment," dated 11/28/23, showed Resident #1 was admitted to the facility on 11/13/23 with diagnosis of dementia.

A "Service Plan," dated 03/06/25, showed Resident #1 wandered with exit seeking behavior. The plan, read in part, "Resident gets agitated when being redirected when found exit seeking." The plan showed Resident #1 was independent

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C1512	Continued From page 4 with mobility and utilized a walker. A "Nurse's Note," dated 03/09/25, read in part, "Resident continues to try and leave out the doors and when redirected resident is combative and refuses to cooperate." A physician's "Progress Note," dated 03/10/25, read in part, "Today the patient is seen with mental status changes and is exit seeking." The progress note showed the resident was prescribed Ativan (an anti-anxiety medication) 0.5 milligrams every six hours as needed. A policy titled "Accepting and Retaining Residents with Dementia in an Unsecured Area," dated 04/01/25, read in part, "Residents with a known history or pattern of elopement should only be accepted/retained in a memory care secured area." On 05/13/25 at 12:34 p.m., OSDH received an incident report. The incident report, read in part, "[Administrator] was contacted by [name withheld] Police Department stating that one of our residents was found wandering down the street about 2 miles from the facility."..."Resident has a history of wandering and elopement behavior." The incident report showed the resident was Resident #1. A document titled "Every 2 Hour Checks [Resident #1]," with dates ranging from 05/13/25 to 05/16/25 showed Resident #1 had 5 exit-seeking episodes, 2 of which were time periods greater than 30 minutes. The document showed on 05/13/25 at 10:15 p.m. to 12:13 a.m., Resident #1 was walking hall trying to get out each door. The document showed on 05/15/25 at 10:45 p.m. to 11:30 p.m., Resident #1 was	C1512		

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C1512	Continued From page 5 attempting to exit the front door. On 05/16/25 at 8:10 a.m., housekeeper #1 stated, "[Resident #1] tries always to go to the exits to get out." They were asked if Resident #1 had ever been successful at elopement. Housekeeper #1 stated, "Yes, the other night she got down the street. Other times [they] was just on the porch." Housekeeper #1 was unable to recall how many times Resident #1 had been able to exit the center unsupervised. On 05/16/25 at 8:59 a.m., CMA #1 was asked how many times Resident #1 had eloped from the center. They stated, "Multiple times, 5 for sure." CMA #1 was asked what interventions were in place to prevent another elopement. They stated, "two hour checks, redirecting when she exit-seeks, and if [they] gets too irate we get [their] [family member] to help us. All of the doors have a new code, too." CMA #1 reported Resident #1 had a family member who lived in another apartment in the center. CMA #1 stated Resident #1 was able to elope on 05/12/25 due to a glitch in the maglock on the exit door. They stated, "It didn't alarm when it was opened." On 05/16/25 at 9:50 a.m., the DON was asked how many times Resident #1 had eloped. They stated, "They've opened doors before, but since February when I started here this is their first elopement." The DON was asked what interventions were in place to prevent another elopement. The DON stated, "We've fixed the maglock, put the resident on every two hour visual checks, and family is trying to get them in memory care. The doctor will see them Monday to try adjusting meds [medication]." On 05/16/25 at 10:54 a.m., the family member of	C1512		

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C1512	Continued From page 6 Resident #1 was asked where the police found Resident #1 on 05/12/25 when they eloped. The family member stated, "I don't know the exact location, just that it was about two miles from the facility." The family member was asked if the resident had ever eloped prior to this incident. They stated, "One other time." They were unable to recall specifics. The family member stated the plan was to relocate Resident #1 to a memory care, but they were unable to give a timeline. They stated, "As soon as their house sells." On 05/16/25 at 11:13 a.m., the maintenance director was asked how Resident #1 was able to elope on 05/12/25. They stated, "The key hole in the maglock had a loose wire, so I detached it, reattached it, and now it's fine." When asked what interventions were in place to prevent malfunctioning exit doors they stated, "We check the maglocks weekly." The maintenance director was asked how many times Resident #1 had eloped. They stated, "[Resident #1] has only gotten off property this once that I know of. They've gotten outside multiple times and I personally have brought her inside a few times. [Resident #1] knows to lean on the exit doors and it will release and open. The exit doors have a fire safety mechanism that will open if the exit bar is pushed down for 15 seconds." On 05/19/25 at 12:05 p.m., CMA #2 was asked what interventions were in place to prevent Resident #1 from eloping before discharge on 05/19/25. They stated, "[Resident #1] had a sitter 24 hrs each day over the weekend and today. We're all checking the doors at the start and end of our shifts." CMA #2 also confirmed Resident #1 moved out of the center today. They stated, "[Resident #1] left about 30, 45 min ago."	C1512		

OKLAHOMA
State Department of Health

Delivery via email to: pabennett@moradalakehefner.com; albaggs@moradalakehefner.com

June 18, 2025

License Number: AL5507

Alex Baggs, Administrator
Morada Lake Hefner
7535 West Hefner Road
Oklahoma City, OK 73162

Survey Event ID: 67O611

Dear Mr. Baggs:

On **May 19, 2025,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 31, 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: 6/11/2013** **Facility Name:** Morada Lake Hefner **License Number:** AL5507 **Survey Event ID:** OK00082252 **Date Survey Completed: 5/19/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1512	Based on: An IJ was determined to exit when the center failed to provide supervision ad intervene for Resident #1 to prevent elopement

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?	1.When an elopement occurs, the resident will receive a physical examination and physician consultation. Notify the resident's family and/or responsible party that the resident has been found. 2. The resident will be reevaluated to determine if the resident is still appropriate for retention in the Community. If the resident's physician deems the resident can remain in the Community, the resident's Plan of Care will be adjusted, and all changes immediately implemented to prevent further elopements. 3. If a resident is no longer deemed safe in the community, a. a one-on-on sitter will be utilized until the resident is placed in a secured environment; or b. the resident will go home with family. 4. Elopement Drills will take place monthly and ED or designated employee will log drill into TELS for compliance. 5. All elopements will be reviewed in Quarterly QA meeting.
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 will have Elopement Risks completed by 5/31/25. All new admissions will have Elopement Risks completed prior to admission.
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?	Elopement drills performed monthly, ED or designee will document in TELS. Elopement Risk Assessments will be completed on each resident at their 6-month assessments or change of condition assessment. All potential residents

	will receive an Elopement Risk Assessment prior to admission.
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.	Elopement Risk Assessments will be completed on all residents/potential residents. If potential resident is deemed to be an elopement risk, DDRC will review medical record to determine if resident is safe in community. All elopement risk residents will be reviewed at quarterly QA meeting. ED and DHW will sign off on QA review
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/31/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Alex Baggs** OAC 310:663-25-4(F)	**Date 6/18/2025**

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

FINAL DETERMINATION NOTICE
USPS Tracking # 7021 2720 0002 0354 1815

June 25, 2025

License Number: AL5507

Alex Baggs, Administrator
Morada Lake Hefner
7535 West Hefner Road
Oklahoma City, OK 73162

Survey Event ID: 67O612

Dear Mr. Baggs:

A revisit conducted **June 19, 2025**, revealed that your facility corrected deficiencies effective **May 31, 2025**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

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
	AL5507	A. BUILDING: _____ B. WING _____	R-C 06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAKE HEFNER	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

(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 06/19//25. All deficiencies from the survey on 05/19/25 were cleared.	{C 000}		

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