OKLAHOMA
State Department
of Health

Delivery via email to: jessica.bieger@gmail.com

April 15, 2024

License Number: AL5519

Ms. Jessica Bieger, Administrator
Vitality Living Village
2333 Manchester Drive
Oklahoma City, OK 73120

RE: Survey Event ID: M3GC11

Dear Ms. Bieger:

On **April 3, 2024**, agents from our office concluded a State Licensure survey with a complaint 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 the deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **April 3, 2024**.

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

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5519	A. BUILDING: _____ B. WING _____	C 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITALITY LIVING VILLAGE	2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120

(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 from 04/01/24 through 04/03/24. A complaint investigation (#OK00063388) was conducted in conjunction with the survey. Facility census: 46 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide RN/DON - registered nurse/director of nurses	C 000		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to coordinate all assessments with a signature by a registered nurse or the resident's personal physician for two (#7 and #8) of eight sampled residents reviewed for comprehensive assessments. Findings: On 04/02/24 at 10:40 a.m., clinical record reviews were conducted with the RN/DON. Resident #7's comprehensive assessment dated 03/21/24 was not signed by the registered nurse or personal physician.	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5519	A. BUILDING: _____ B. WING _____	C 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITALITY LIVING VILLAGE	2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120

(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 542	Continued From page 1 Resident #8's comprehensive assessment dated 04/01/24 was not signed by the registered nurse or personal physician. On 04/02/24 at 10:40 a.m., the RN/DON stated neither assessment included their signature or the resident's personal physician's signature. On 04/03/24 at 9:15 a.m., the RN/DON reported it was the center's policy for them to sign the assessments and have the resident/resident representative sign the assessment.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative or the resident's personal physician and the person completing the form for two (#7 and #8) of eight sampled residents reviewed for comprehensive assessments. Findings:	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5519	A. BUILDING: _____ B. WING _____	C 04/03/2024

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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
C 543	Continued From page 2 On 04/02/24 at 10:40 a.m., clinical record reviews were conducted with the RN/DON. Resident #7's comprehensive assessment dated 03/21/24 was not signed by the resident and/or their representative. Resident #8's comprehensive assessment dated 04/01/24 was not signed by the resident and/or their representative. On 04/02/24 at 10:40 a.m., the RN/DON stated neither assessment had been signed to include a personal interview between the resident or the resident's representative and the person who completed the form. On 04/03/24 at 9:15 a.m., the RN/DON reported it was the center's policy for them to sign the assessments and have the resident/resident representative sign the assessment.	C 543		
C1304 SS=E	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.	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITALITY LIVING VILLAGE	2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120

(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 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a working emergency call system was available per resident's service contract for two (#2 and #9) of three cognitive residents reviewed for emergency call system in their personal bathroom. The RN/DON reported 46 residents resided in the facility. Findings: 1. Resident #2 resided on the memory care unit with diagnoses which included major depressive disorder, seizures, and dementia. Resident #2's "Service Agreement," dated 07/15/22, read in part, "...Maintenance and Repair Service...The community will perform and provide routine repairs, maintenance, and replacement of property and equipment it owns...The Community will provide arrange services to its resident...We will provide residents with its Evacuation Plan/Emergency Call System during the move-in process...It is also available upon request ..." Resident #2's "Quarterly" assessment, dated 01/08/24, documented no assistance required with transfers and toileting. Resident #2's "Service Plan," dated 01/08/24, documented "...Emergency response: Resident will maintain and/or maximize current level of	C1304		

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VITALITY LIVING VILLAGE	2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120

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C1304	Continued From page 4 functioning with emergency...Interventions: Emergency pull cord..." 2. Resident #9 resided on the memory care unit with diagnoses which included dementia, chronic pain, and osteoarthritis. Resident #9's "Service Agreement," dated 11/21/22, read in part, "...Maintenance and Repair Service...The Community will perform and provide routine repairs, maintenance, and replacement of property and equipment it owns...The Community will provide arrange services to its residents ...We will provide residents with its Evacuation Plan/Emergency Call System during the move-in process ...It is also available upon request ..."" Resident #2's "Quarterly" assessment, dated 03/20/24, documented no assistance required with transfers and toileting. Resident #2's "Service Plan," dated 03/26/24, documented "...Emergency response: Resident will maintain and/or maximize current level of functioning with emergency ...Interventions: Emergency pull cord..." On 04/01/24 at 12:44 p.m., the emergency pull cords were tested on the memory care unit with the business office manager. The emergency pull cords in resident #2 and #9's bathrooms were tested with the business office manager and confirmed to not be functioning. The emergency pull cord did not alarm the facility walkie talkie/radio system, the business office manager reported the emergency pull cords should be checked regularly by staff. The business office manager reported the company would be called to fix the emergency pull cords.	C1304		

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	AL5519	A. BUILDING: _____ B. WING _____	C 04/03/2024

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C1304	Continued From page 5 On 04/01/24 at 1:13 p.m., resident #2 reported they had never used the emergency pull cord in the bathroom and was not aware that it was not working. On 04/01/24 at 1:16 p.m., CMA #2 reported residents #2 and #9 could use the emergency pull cords. 04/03/24 at 9:10 a.m., resident #9 reported they had never needed to use the emergency pull cord in the bathroom and was not aware it had not been working. 04/03/24 at 9:15 a.m., the RN/DON reported an emergency response policy was available to residents upon request. The RN/DON was waiting for cooperate to send the policy and had not been able to provide the policy before the survey was completed.	C1304		

OKLAHOMA
State Department
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Delivery via email to: jessica.bieger@gmail.com

April 26, 2024

License Number: AL5519

Ms. Jessica Bieger, Administrator
Vitality Living Village
2333 Manchester Drive
Oklahoma City, OK 73120

RE: Survey Event M3GC11

Dear Ms. Bieger:

On **April 3, 2024**, a Licensure inspection with a complaint survey was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 18, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
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: 4/23/2024** **Facility Name:** Vitality Living Village **License Number:** AL5519 **Survey Event ID:** M3GC11 **Date Survey Completed: 4/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542	Based on: The rule is not met as evidenced by based on record review and interview, the center failed to coordinate all assessments with a signature by a registered nurse or the resident's personal physician for two (#7 and #8) of eight sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

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?	The registered nurse signed resident #7 and resident #8's assessments on (4/01/2024). The physician signed resident #7 and #8's assessments on (04/01/2024).
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit was completed of current resident assessments, by the Director of Wellness, on (4/3/2024) to verify presence of all signatures. Any discrepancies that were identified will be correctedwithin 45 days of discovery.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Executive Director educated the Director of Wellness on (04/03/2024) regarding the requirements of the resigstered nurse and personal physician signature.
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.	The Director of Wellness and/or designee will audit 6 assessments for signatures weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month. The results of the audits will be discussed in the monthly QA meetings. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/18/2024
OSDH Response: Element accepted Yes ☐ No ☐	

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

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/23/2024** **Facility Name:** Vitality Living Village **License Number:** AL5519 **Survey Event ID:** M3GC11 **Date Survey Completed: 4/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 543	Based on: The rule is not met as evidenced by based on record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative or the resident's personal physician and the person completing the form for two (#7 and #8)of eight sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

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?	The registered nurse signed resident #7 and resident #8's assessments on (4/01/2024). The physician signed resident #7 and #8's assessments on (4/01/2024). The resident or resident's representative for resident #7 and resident #8 were included in a personal interview and signed the assessment on (4/01/2024 and 4/09/2024).
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit was completed of current resident assessments, by the Director of Wellness, on (4/3/2024) to verify presence of all signatures. Any discrepancies that were identified will be corrected within 45 days of discovery
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Executive Director educated the Director of Wellness on (4/03/2024) regarding the requirements of the registered nurse signature, personal physician signature, and personal interview between the resident or resident's representative and the person completing the form.
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.	The Director of Wellness and/or designee will audit 6 assessments for signatures and personal interviews weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month. The results of the audits will be discussed in the monthly QA meetings. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system:

	Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/18/2024
OSDH Response: Element accepted Yes ☐ No ☐	

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

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/23/2024** **Facility Name:** Vitality Living Village **License Number:** AL5519 **Survey Event ID:** M3GC11 **Date Survey Completed: 4/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1304	Based on: The rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a working emergency call system was available per resident's service contract for two (#2 and #9) of three cognitive residents reviewed for emergency call system in their personal bathroom.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

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?	The emergency call system in resident #2 and #9 bathrooms was repaired on (4/02/2024) by A-Sentrics.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit was completed of all bathroom emergency call systems on (4/02/2024). Any system found not working was repaired at the time of discovery.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Executive Director educated the Maintenance Director on (4/02/2024) regarding the emergency call system and the requirement for it to be in working order.
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.	The Maintenance Director and/or designee will audit 6 resident rooms for working emergency call system weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month. The results of the audits will be discussed in the monthly QA meetings. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/25/2024
OSDH Response: Element accepted Yes ☐ No ☐	

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

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department
of Health

Delivery via email to: jessica.bieger@gmail.com

June 25, 2024

License Number: AL5519
Survey Event ID: M3GC12

Ms. Jessica Bieger, Administrator
Vitality Living Village
2333 Manchester Drive
Oklahoma City, OK 73120

Dear Ms. Bieger:

On **June 21, 2024**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **June 21, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **May 18, 2024**.

If you have any questions concerning the information in this letter, please contact this office 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
	AL5519	A. BUILDING: _____ B. WING _____	R-C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RADIANCE SENIOR LIVING AT THE VILLAGE	**2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 06/21/24. 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