OKLAHOMA
State Department
of Health

Delivery via email to: cheryl.seabaugh@quailridgeassistedliving.com

April 1, 2024

License Number: AL5523

Ms. Cheryl Seabaugh, Administrator
Quail Ridge Senior Living
12401 Trail Oaks Drive
Oklahoma City, OK 73120

RE: Survey Event ID: YQ0311

Dear Ms. Seabaugh:

On **March 19, 2024**, 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.

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 Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required

evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR in a timely manner 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: IDRCoordinator@health.ok.gov

Or by **mail** 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: **Quail Ridge Sr Living**
Address: **12401 Trail Oaks Dr**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5523**
Complaint #: **OK00062142**
Investigation Date(s): **02/27/24, 02/28/24, 03/11/24 – 03/15/24, 03/18/24, and 03/19/24**

ALLEGATION(S)

The center failed to ensure residents were assessed in a timely manner after fall.
The center failed to ensure residents were served meals or assisted to the dining room at meal times.

An unannounced on-site investigation was initiated 02/27/2024 at 8:31 a.m.

A sample of 3 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 investigation related to resident records, incident reports, and weight loss was conducted.

At the time of the survey, the center provided documentation about assistance with falls.

At the time of the survey, no resident complained about not receiving help from staff after a fall.

At the time of the survey, staff stated they helped residents who fell.

At the time of the survey, there was no deficient practice related to timely assessments at the time of a fall.

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: 03/20/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Quail Ridge Sr Living**
Address: **12401 Trail Oaks Dr**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5523**
Complaint #: **OK00062626**
Investigation Date(s): **02/27/24, 02/28/24, 03/11/24 – 03/15/24, 03/18/24, and 03/19/24**

ALLEGATION(S)

The center failed to ensure a clean, comfortable, and homelike environment.

An unannounced on-site investigation was initiated 02/27/2024 at 8:31 a.m.

A sample of 3 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 investigation related to heating units, electric heating blankets, maintenance log records, and resident records was conducted.

At the time of the survey, no heating units were observed not working.

At the time of the survey, no electric blankets were observed being used by residents.

At the time of the survey, no resident complained about their heating unit not working.

At the time of the survey, no resident claimed to use an electric heating blanket.

At the time of the survey, no staff knew of any of the heating units being out of service.

At the time of the survey, no staff knew of any resident using an electric heating blanket.

At the time of the survey, there was no deficient practice related to a utility outage.

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: 03/20/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Quail Ridge Sr Living**
Address: **12401 Trail Oaks Dr**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5523**
Complaint #: **OK00062820**
Investigation Date(s): **02/27/24, 02/28/24, 03/11/24 – 03/15/24, 03/18/24, and 03/19/24**

ALLEGATION(S)

The center failed to provide adequate supervision to prevent falls with major injury and ensure medications were administered to the right residents, according to physician orders.
The center failed to ensure residents/resident representatives were notified of a change in condition.
The center failed to provide timely incontinent care for dependent residents.
The center failed to ensure an administrator/manager was available to oversee the center's operations.

An unannounced on-site investigation was initiated 02/27/2024 at 8:31 a.m.

A sample of 3 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 investigation related to resident records, incident reports, investigations, hospital records, nurse's notes, incontinent care, wound care, staffing, resident representative notification, and administration was conducted.

At the time of the survey, staff were observed providing incontinent care.

At the time of the survey, there was no skin breakdown or wounds observed in the peri-area or bottoms of dependent residents.

At the time of the survey, the center provided documentation of resident representative notifications.

At the time of the survey, the center provided documentation of administrator coverage.

At the time of the survey, no resident complained about not receiving incontinent care.

At the time of the survey, no family member complained about being notified by the center, communicating with the nurse or administrator, incontinent care provided to their family member, or staffing.

At the time of the survey, staff stated they provided incontinent care at least every 2 hours, sometimes more frequently depending on the resident's needs.

At the time of the survey, staff stated family was notified of falls and/or changes in condition of the resident.

At the time of the survey, staff stated if family called and wanted updates about their family member or express concerns they would re-route the call to the DON and/or Administrator.

At the time of the survey, there was no deficient practice cited in relation to staffing, resident representative. notification, incontinent care, or Administrator oversight.

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: 03/20/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **QRSL**
Address: **12401 Trail Oaks Drive**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5523**
Complaint #: **OK00063439**
Investigation Date(s): **02/27/24, 02/28/24, 03/11/24 – 03/15/24, 03/18/24 and 03/19/24**

ALLEGATION(S)

The center failed to ensure food was served according to residents' preference and in adequate portions.
The center failed to ensure adequate transportation was provided and failed to ensure beauty salon services were available.
The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 02/27/2023 at 8:31 a.m.

A sample of 3 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 investigation related to the dining room, menus, dining room staff, transportation, the beauty salon, and food was conducted.

A test tray was obtained. The presentation was appealing with good portions and great taste.

Dining room staff were observed taking resident orders and delivering their orders to their tables.

Residents were observed being loaded into the center's van for transport to appointments. The transportation policy was observed posted at the main entrance near the concierge.

Residents were observed in the beauty salon receiving services. The salon hours were observed posted outside the salon along with services and gift certificates available. The salon also had a business card available at the main entrance.

Resident's described the food as "Delicious," "Wonderful," "We recommend it," "Very satisfying."

At the time of the survey, no resident complained about the staffing in the dining room or the closed off section in the dining room.

Resident's described the beauty salon employee as "Nice," and accommodating.

Resident's stated they hadn't had any problems with transportation. They stated they just go to the front desk and they'll set it up.

Dining room staff stated there were at least four servers during each meal.
Dining room staff stated they had not had any complaints from residents.

Dining staff stated the section of the dining room "closed" was used for reservations and parties. It was decided since the center was not at full capacity, during regular meals the section furthest from the kitchen would remain closed for residents to seat, socialize, and interact with others instead of by themselves.

Staff stated residents make appointments with the beauty salon.

Staff stated the center provided transportation to appointments.

Staff also stated activities also participated in transportation.

At the time of the survey, there was no deficient practiced cited related to dietary services, transportation, beauty salon services, or dining room staffing.

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: 03/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5523	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL RIDGE SENIOR LIVING	12401 TRAIL OAKS 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 02/27/24, 02/28/24, and 03/11/24 through 03/15/24, 03/18/24 and 03/19/24. Complaint investigations (#OK00062142, OK00062626, OK00062820, and #OK00063439) was conducted in conjunction with the survey. Resident census was 130. Listed below are abbreviations that will be used throughout this document. DON - director of nursing d/t - due to EMS - emergency medical services EMSA - emergency medical services authority FSBS - fingerstick blood sugar FSG - fingerstick glucose LPN - licensed practical nurse ODH - Oklahoma Department of Health U - units	C 000		
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.	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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C1304	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the center failed to ensure a safe home like envionment according to the service agreement for 1 (#9) of 1 sampled residents who was using a heating pad in their room, at the time of the survey. The "Resident Service Contract," read in part, "...Safe Living Environment...The Community will provide a home-like living envrionment and make reasonable efforts to ensure that no physical or care-related factors cause, or contribute to, a fall or accident by the Resident..." On 03/12/24 at 1:08 p.m., resident #9 was observed in their room, sitting in their chair with a heating pad at their left side. On 03/14/24 at 12:16 p.m., the assistant administrator stated (as they observed the heating pad in the resident's room) the resident should not be using a heating pad. They stated, "It could burn them." On 03/19/24 at 12:33 p.m., CMA #4 stated (resident #9) used a heating pad. On 03/19/24 at 3:25 p.m., the maintence supervisor stated they did not know of any resident using an electric blanket or heating pad.	C1304		
C1505 SS=G	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care	C1505		

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	AL5523	A. BUILDING: _____ B. WING _____	C 03/19/2024

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QUAIL RIDGE SENIOR LIVING	12401 TRAIL OAKS DRIVE OKLAHOMA CITY, OK 73120

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C1505	Continued From page 2 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 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 observation, interview, and record	C1505		

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	AL5523	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 3 review, the center failed to: 1. Administer physician ordered insulin for 1 (#13) of one resident who received their insulin from home health as ordered by the physician, but received an additional dose of insulin without a physician's order by the center's (former) LPN, with resident FSBS 30 per EMSA and was hospitalized; and 2. Secure portable oxygen tanks for 1 (#18) of 1 resident who used portable oxygen tanks when leaving their room. Findings: 1. A "Comprehensive Assessment," dated 05/02/2022, read in part, resident #13 "...alert and oriented x1 (self), confused at times and forgetful with poor judgment...poor mobility, strength, and gait...ambulatory with staff assistance using a walker...1 person assist with bathing, eating, dressing, transferring, toileting, and ambulation...poor ability to communicate...not interviewable...incontinent of bladder and bowel using adult briefs with assist..." An "Incident Report," dated 08/05/22, read in part, "...at 10:00 p.m....nursing administrator was notified of medication error...Levemir...the LPN on duty administered an extra 5U dose of Levemir to resident without physicians order d/t high blood sugar..." Resident #13 hospital records, dated 08/06/22, read in part, "...likely toxic-metabolic in the setting of hypoglycemia...presented to the ED for evaluation of altered mental status and decreased responsiveness...EMS was contacted...FSG was found to be 30...the night	C1505		

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	AL5523	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 4 prior to presentation she received an extra determir 7U by mistake...severe hypoglycemia..." On 03/19/24 at 3:13 p.m., the DON stated an additional dose of insulin was given by the center's nurse without a physician's order. 2. On 03/14/24 at 12:03 p.m., the assistant Administrator observed with resident #18; three large free standing full oxygen tanks (last up to 7 hours) and one large free standing empty oxygen tank; and four small free standing full oxygen tanks (last up to 3 hours) and ten small free standing empty oxygen tanks. The assistant Administrator stated, "We need trays."	C1505		
C1914 SS=E	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on interview and record review, the center failed to provide evidence reportable events were reported to the department for 4 (#2, 15, 16, and #17) of 4 sampled residents who had reportable events with missing documentation. An incident report, dated, 01/10/24, documented,	C1914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1914	Continued From page 5 resident #2 had an allegation of abuse/mistreatment. An incident report, dated 01/26/24, documented, resident #15 had a fall and complained of left hip pain and was sent to the emergency department. An incident report, dated 02/04/24, documented, resident #16 entered resident #17's room, was aggressive and yelling, resident #16 pushed resident #17 causing them to fall and hit their head. Resident #16 was sent out for a psych eval and resident #17 refused treatment. On 03/14/14 at 9:57 a.m., the assistant administrator was asked how they knew these reportable events had been reported to the Department without a faxed receipt. They stated there was no way of knowing if the Department received the reportable events.	C1914		
C1916 SS=D	310:663-19-1(f) REPORTS TO THE DEPARTMENT (f) Each continuum of care facility and assisted living center shall report allegations and occurrences of resident abuse, neglect, or misappropriation of resident's property by a nurse aide to the Nurse Aide Registry by submitting a completed "Notification of Nurse Aide Abuse, Neglect, Mistreatment or Misappropriation of Property" form (ODH Form 718), which requires the following: (1) facility/center name, address and telephone; (2) facility type; (3) date; (4) reporting party name or administrator name; (5) employee name and address; (6) employee certification number;	C1916		

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C1916	Continued From page 6 (7) employee social security number; (8) employee telephone number; (9) termination action and date (if applicable); (10) other contact person name and address; and (11) the details of the allegation or occurrence of abuse, neglect, or misappropriation of resident property. This Rule is not met as evidenced by: Based on interview and record review, the center failed to provide evidence a nurse aide was reported to the nurse aide registry for 1 (#2) of 1 sampled resident where an allegation of abuse/mistreatment had missing documentation. An incident report, dated, 01/10/24, documented resident #2 had an allegation of abuse/mistreatment by a staff during an emergency first aide situation where the staff had hit the resident on the arm. The employee was terminated. On 03/14/24 at 9:57 a.m., the assistant Administrator was asked how they knew the nurse aide registry had been notified without a ODH form 718 and no fax receipt. They stated there was no way to know if the nurse aide had been reported to the nurse aide resgistry because there was no ODH form 718 or a fax receipt.	C1916		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident	C1951		

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QUAIL RIDGE SENIOR LIVING	12401 TRAIL OAKS 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
C1951	Continued From page 7 admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, interview, and record review, the center failed to complete: a) a significant change assessment for 1 (#2) of 1 sampled resident who required a significant change assessment, and b) an individualized care plans for seven (#1, 3, 4, 5, 8, 9 and #10) of 10 sampled residents who had missing documentation to help staff care for the residents. Findings: 1. A "Comprehensive Assessment," dated 03/02/24, read in part, resident #1 "...had a diagnosis of dementia...alert and oriented x 2 (person, place)...confused with fair judgment...one person assist eating...continent of bowel...independent eating...good ability to communicate..." A "Care Plan," dated, 07/08/23, read in part, resident #1 "...is incontinent of bowel. Plays in fecal matter..." It did not document they needed help eating or forgot how to use the call light or if they were able to express their needs. 2. A "Comprehensive Assessment," dated 09/06/23, read in part, resident #2 "...had diagnoses of Alzheimer's and depression...had fair mobility, strength and gait...good ability to communicate..."	C1951		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5523	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL RIDGE SENIOR LIVING	12401 TRAIL OAKS 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
C1951	Continued From page 8 Resident #2 was observed sitting up in a broda chair, unable to answer questions A "Care Plan," dated 05/25/23, read in part, resident #2 "...is independent with meals, eating and drinking...responds to reorientation and redirection when wandering...requires reminders/cues to use the toilet...is continent of bowels... 3. A "Comprehensive Assessment," dated 12/18/23, read in part, resident #3 "...had a diagnosis of thoracic aortic aneurysm..." Resident #3 was taking an anticoagulant (coumadin) with weekly PT/INRs. A "Care Plan," dated 12/28/23, read in part, "...skin condition...is on medication which causes bleeding/brusing...medication...history of pain...history of constipation..." It did not document resident #3 was taking an anticoagulant with weekly PT/INRs for monitoring. 4. A "Comprehensive Assessment," dated 02/13/24, read in part, resident #4 "...Type 2 Diabetes Mellitus..." A "Care Plan," dated 02/13/24, did not document diabetes with interventions to include insulin, fsbs, or the use of Dexcom or s/s of hypoglycemia or hyperglycemia. 5. A "Comprehensive Assessment," dated 03/02/24, read in part, resident #5 "...Type 2 Diabetes Mellitus with hyperglycemia..." A "Care Plan," dated 02/28/24, did not document	C1951		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5523	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL RIDGE SENIOR LIVING	12401 TRAIL OAKS 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
C1951	Continued From page 9 diabetes with hyperglycemia with interventions to include fsbs, insulin or oral medication, or monitoring A1C, or what would staff do if/when resident #5 became hyperglycemic. Resident #5 had resolved skin issues, but their skin was not care planned. They were also taking lasix, but the care plan did not include monitoring weights. 6. A "Comprehensive Assessment," dated 02/19/24, did not include their supra-pubic catheter. A "Care Plan," dated 01/31/23, read in part, resident #8 "...continent of bladder...needs assistance to use toilet and maintain bladder continence..." 7. A "Comprehensive Assessment," dated 02/21/24, read in part, resident #9 "...chronic pain...continent of bladder..." A "Care Plan," dated 08/31/22, read in part, "...incontinent of both bowel and bladder...staff will assist...as much as may require with toileting/personal hygiene..." 8. A "Comprehensive Assessment," dated 03/02/24, read in part, resident #10 "...one person assist dressing...incontinent of bowel...fair skin..." A "Care Plan," dated 01/15/23, read in part, "...takes initiative and responsibility dressing and undressing self without assistance...assistance needed to use toilet and maintain bowel continence...grooms self without assistance..." Resident #10s bilateral lower extremities were not documented. Resident #10 was observed in bed with gauze bandages wrapped around their bilateral lower	C1951		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5523	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL RIDGE SENIOR LIVING	12401 TRAIL OAKS 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
C1951	Continued From page 10 extremities. On 03/18/24 at 4:26 p.m., the DON stated it would be important to update comprehensive assessments when there was a significant change which affected more than one of area of the resident's health status. On 03/18/24 at 5:11 p.m., the DON stated it would be important for the resident's care plans to be individualized with interventions.	C1951		

OKLAHOMA
State Department
of Health

Delivery via email to: cheryl.seabaugh@quailridgeassistedliving.com

April 15, 2024

License Number: AL5523

Ms. Cheryl Seabaugh, Administrator
Quail Ridge Senior Living
12401 Trail Oaks Drive
Oklahoma City, OK 73120

RE: Survey Event YQ0311

Dear Ms. Seabaugh:

On **March 19, 2024**, a Licensure inspection 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 15, 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: 4/8/2024** **Facility Name:** Quail Ridge Senior Living **License Number:** AL5523 **Survey Event ID:** YQ0311 **Date Survey Completed:** 3/19/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304	Based on: observation, interview and record review, the center failed to ensure a safe home like envionment according to the service agreement for 1 (#9) of 1 sampled residents who was using a heating pad in their room, at the time of the survey.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn their from. The POC is intended to constitute the facility's written allegation of continued compliance.

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?	Heating pad was removed from identified resident (#9) apartment.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No other residents use heating pads, therefore no other residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Staff will be in-serviced on the risks of heating pads and proper reporting procedures if they observe them being used by residents.
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.	Audits will be conducted be the administrator/designee to ensure no residents are using heating pads . Audits will by conducted weekly for one month, then monthly for two months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Cheryl Seabaugh** OAC 310:663-25-4(F)	**Date 4/8/2024**

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: 4/8/2024** **Facility Name:** Quail Ridge Senior Living **License Number:** AL5523 **Survey Event ID:** YQ0311 **Date Survey Completed:** 3/19/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: observation, interview, and record review, the center failed to:1. Administer physician ordered insulin for 1 (#13) of one resident who received their insulin from home health as ordered by the physician, but received an additional dose of insulin without a physician's order by the center's (former) LPN, with resident FSBS 30 per EMSA and was hospitalized; and 2. Secure portable oxygen tanks for 1 (#18) of 1 resident who used portable oxygen tanks when leaving their room.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn their from. The POC is intended to constitute the facility's written allegation of continued compliance.

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?	Former LPN who administered the extra insulin dose without physician order was terminated. Current nursing staff responsible for administering insulin in-serviced on administering meds per physicians orders. Oxygen tanks for identified resident (#18) were secured in a oxygen rack.
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 with physician orders and oxygen have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Staff will be inserviced on medication administration per physicians orders and proper O2 storage.
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.	Audits will be conducted be the administrator/designee to ensure medications are being administered per physician orders and oxygen is being stored appropriately. Audits will by conducted weekly for one month, then monthly for two months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Cheryl Seabaugh OAC 310:663-25-4(F)			**Date 4/8/2024**
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: 4/8/2024** **Facility Name:** Quail Ridge Senior Living **License Number:** AL5523 **Survey Event ID:** YQ0311 **Date Survey Completed:** 3/19/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1914	Based on: interview and record review, the center failed to provide evidence reportable events were reported to the department for 4 (#2, 15, 16, and #17) of 4 sampled residents who had reportable events with missing documentation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living (the facility) as to the accuracy of the surveyors, their findings, nor their conclusions drawn their from. The POC is intended to constitute the facility's written allegation of continued compliance.

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?	Incidents for identified residents (#2, 15, 16, and 17) were re-submitted to OSDH with confirmation sheets retained.
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 with incident reports meeting OSDH reporting requirements have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Nursing administration will be in-serviced on reporting guidelines including reporting criteria and timelines.
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.	Audits will be conducted be the administrator/designee to ensure incident reports requiring OSDH notifications are made per regulatory timelines and confirmations are retained. Audits will by conducted weekly for one month, then monthly for two months. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Cheryl Seabaugh** OAC 310:663-25-4(F)	**Date 4/8/2024**

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
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OKLAHOMA State Department of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/8/2024

Facility Name: QUAIL RIDGE SENIOR LIVING

License Number: AL5523

Survey Event ID: YQ0311

Date Survey Completed: 3/19/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1916	Based on: interview and record review, the center failed to provide evidence a nurse aide was reported to the nurse aide registry for 1 (#2) resident where an allegation of abuse/mistreatment had missing documentation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction (POC) is submitted as required under federal and state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living as to the accuracy of the surveyors, their findings, nor conclusions drawn from their form. The POC is intended to constitute the facility's written allegation of continued compliance.

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 nurse aide employee was terminated. The reportable documentation has been completed and submitted to the nurse aide registry and documentation has been retained at the facility for evidence of such report.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident involved in allegations of abuse/mistreatment have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All health and wellness staff will be in-serviced on comprehensive reportable events and the full process of department forms required for reportable events, including notifications to the NAR, APS, and police dept. A binder for reportable incidents will be implemented to ensure monitoring and compliance.
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.	Audits will be conducted by the administrator/DON/designee to ensure timely compliance and notifications as required. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the QA binder and the POC binder as evidence of the correction. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Cheryl Seabaugh** Cheryl Seabaugh **Date 4/8/2024**

OAC 310:663-25-4(F)

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.
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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/8/2024** **Facility Name:** QUAIL RIDGE SENIOR LIVING **License Number:** AL5523 **Survey Event ID:** YQ0311 **Date Survey Completed: 3/19/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1951	Based on: Based on observation, interview, and record review, the center failed to complete: a) a significant change assessment for 1 (#2) resident who required a significant change assessment, and b) an individual care plans for 7 (#1, 3, 4, 5, 8, 9, and #10) residents who had missing documentation to help staff care for the residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction (POC) is submitted as required under federal and state law. The submission of this POC does not constitute an admission on the part of Quail Ridge Senior Living as to the accuracy of the surveyors, their findings, nor conclusions drawn from their form. The POC is intended to constitute the facility's written allegation of continued compliance.

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?	a) A change assessment was completed for resident #2. b) Individual care plans have been completed for residents #1, #3, #4, #5, #8, #9 and #10.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Comprehensive change assessments and individualized care plans are required for all residents, therefore, all residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All health and wellness staff will be in-serviced on significant change assessments and comprehensive individualized care plans, requirements and timeframes. An audit will be conducted of the residents assessments and care plans to ensure significant change assessments have been completed as required. An assessment binder with current assessment dates and due dates will be implemented to ensure assessments and care plans are completed in a timely manner.
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.	Audits will be conducted by the DON/designee to ensure significant change assessments are completed as required. Audits will be conducted weekly x1 month then monthly ongoing. Progress and findings will be monitored by the QA committee to ensure continued effectiveness. Audits will be brought to the QA committee and filed in the QA binder and the POC binder as evidence of the correction. Enter methods to keep monitoring records:

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Cheryl Seabaugh** OAC 310:663-25-4(F)			**Date 4/8/2024**
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.			
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OKLAHOMA
State Department
of Health

FINAL DETERMINATION

USPS Tracking # 7021 2720 0002 0354 1686

Delivered by email to: cheryl.seabaugh@quailridgeassistedliving.com

May 23, 2024

License Number: AL5523

Ms. Cheryl Seabaugh, Administrator
Quail Ridge Senior Living
12401 Trail Oaks Drive
Oklahoma City, OK 73120

Survey Event ID: YQ0312

Dear Ms. Seabaugh:

A revisit conducted **May 22, 2024**, revealed that your facility corrected deficiencies effective **May 15, 2024**.

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,

Tempal Killman

Tempal Killman, 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
	AL5523	A. BUILDING: _____ B. WING _____	R-C 05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL RIDGE SENIOR LIVING	12401 TRAIL OAKS 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 05/22/24. 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