OKLAHOMA
State Department
of Health

Delivery via email to: rharvey@sagora.com; kmalinga@sagora.com; ncook@sagora.com

April 7, 2023

License Number: AL5525

Ms. Rhonda Harvey, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event ID: 2MU911

Dear Ms. Harvey:

On **April 6, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on April 6, 2023.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action

against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Lyndale at Edmond**
Address: **1225 Lakeshore Dr**
City, State, Zip: **Edmond, OK 73013**
Provider #: **AL5525**
Complaint #: **OK00060099**
Investigation Date(s): **04/04/23-04/06/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have and/or implement effective infection control procedures to prevent communicable disease.	**US**

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 04/04/2023 at 9:40 a.m.

A sample of three residents including any identified resident(s), 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to Chapter 257 Food Service Establishment Regulation was conducted.

The person identified in the complaint did not reside in a state regulated center.

Any communicable diseases required to be reported to the department was followed per regulation.

No resident stated they had any communicable disease that hadn't been reported to the department.

The staff stated communicable diseases were reported to the department as required.

At the time of the survey, there was no deficient practice related to infection control.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 04/06/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Lyndale at Edmond**
Address: **1225 Lakeshore Drive**
City, State, Zip: **Edmond, OK 73013**
Provider #: **AL5525**
Complaint #: **OK00060233**
Investigation Date(s): **04/04/23-04/06/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents' medications were not misappropriated.	**US**
2. The center failed to report misappropriation of resident medications to the State Agency (OSDH).	**US**

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 04/04/2023 at 9:40 a.m.

A sample of three residents including any identified resident(s), 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to narcotics, individual narcotic count records, resident records and audits of medication carts was conducted.

At the time of the survey, medication passes and each shift were observed.

At the time of the survey, no resident complained about missing narcotics.

At the time of the survey, no staff identified missing narcotics.

At the time of the survey, there was no deficient practice related to misappropriation of property.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to incident reports and internal investigations were conducted.

At the time of the survey, there were no missing narcotics observed.

At the time of the survey, no resident complained about missing narcotics.
At the time of the survey, staff stated there were no problems with the narcotics or the narcotic sheets.

At the time of the survey, there was no deficient practice related to reporting misappropriation to the State Agency (OSDH).

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 04/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING: _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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 04/04/23 through 04/06/23. Complaint investigations (#OK00060099 and #OK00060233) were conducted in conjunction with the survey.	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to label, date and store food according to Chapter 257 Food Service Regulations and their company policy. LPN #1 reported to have a census of 37 residents being served at the center. Findings: The "Food Handling" policy, revised 01/2018, read in part, "...All time and temperature control for safety (TCS) leftovers are labeled covered, and dated when stored..." On 04/04/23 at 10:06 a.m, it was observed that a pan of food (meatballs) was sitting in the walk-in refrigerator. During the interview, the CDM stated, "This is leftover meatballs I put in yesterday evening. It should be dated, labeled and covered."	C 391		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING: _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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 1 (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the center failed to provide palatable food accoring to company service contract for four (#5-#8) of four residents who complained about the chicken served at lunch. LPN #1 reported a census of 37 residents in the Assisted Living center. Findings: An undated "Food Service Contract" policy, read in part, "...Play with colors, shapes and textures to ensure diners are not overwhelmed. The presentation should never overpower flavor and function..." The "Resident Council" report, dated 12/28/22 at 2:15p.m., documented that culinary chicken was a little dry. Resident stated, "On Christmas day	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING: _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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 2 the meal wasn't the best." On 04/05/23 at 1:14p.m., a test tray was requested. The fried chicken was observed and found that the chicken was tough in texture and difficult to cut through. At 4:38 p.m, resident #6 stated the pieces of meat could be a challenge to eat. At 4:40p.m, resident #7 stated that "the food is ruff to eat". Resident #8 stated, "it's hard for me to chew the meat. At 4:15p.m, resident #5 stated, " the food is ok, but it's hard to chew.	C1304		

OKLAHOMA
State Department
of Health

Delivery via email to: rharvey@sagora.com; ncook@sagora.com

April 24, 2023

License Number: AL5525

Ms. Rhonda Harvey, Administrator
Lyndale at Edmond
1225 Lakeshore Drive
Edmond, OK 73013

Survey Event ID: 2MU911

Dear Ms. Harvey:

On **April 6, 2023,** a licensure survey and a complaint investigation were 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 **June 1, 2023**.

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

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2023.04.24 15:37:46 -05'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

enc

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/21/2023

Facility Name: Lyndale Edmond Assisted Living

License Number: AL5525

Survey Event ID: 2MU911

Date Survey Completed: 4/6/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391 SS=F	Based on: observation and interview the facility failed to label, date and store food according to Chapter 257 Food Service Regulations and their company policy.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Inservice Culinary staff on requirements of chapter 257 and Lyndale policy for dating and labeling covered food.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Culinary Director will be responsible for conducting quality checks daily to ensure that all food items that are covered are dated and labeled.
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?	Culinary Director will document quality checks daily ensuring that all covered food products are dated and labeled and document education that is provided.
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.	Executive Director will conduct unannounced walk throughs in the kitchen to ensure that dating and labeling of covered food items is being completed according to Chapter 257 and Lyndale Policy. Executive Director will document findings of unannounced rounds and what corrective actions were needed if any. Culinary Director and Executive Director will review progress of dating and labeling of uncovered food items in quality assurance meetings moving forward. Culinary Director will keep a binder with a spreadsheet that indicates the quality checks, any education provided and to whom. The Executive Director will have a binder with documented unannounced visits and results of observations.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/1/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Rhonda Nairey — **Date** Enter a date of signature. 4/21/23
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.
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: 4/21/2023** **Facility Name:** Lyndale Edmond Assisted Living **License Number:** AL5525 **Survey Event ID:** 2MU911 **Date Survey Completed:** 4/6/2023

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304 SS=E	Based on: record review, observation, and interview the center failed to provide palatable food accoring to company service contract for four (#5-#8) of four residents who complained about the chicken served at lunch.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Inservice with Culinary team members. Discussed the dissatisfaction of resident with some of the food that is being served to them. Discussed ways to address the concers of the residents moving forward.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Developed Resident Food Council Meeting. This group meets to discuss Culinary and Food concerns and ways to improve quality. The RDO and Lifestyles Director will take part in each Resident Food Council Meeting which is being held bi-weekly with the information from the meeting being shared with the Culinary Director to implement the requested changes.
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?	Resident Food Council Meeting being held every other week, notes are taken at each meeting. Regional Director of Operations will follow up with the Culinary Director with the concerns and desires of the Residents and in turn the RDO will be at each Bi-weekly meeting to follow up with the Residents. Lyndale Edmond Assisted Living has also recruited and hired a Sous Chef with an extensive amount of experience in Assisted Living that will elevate our dining experience for our 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.	The Bi-Weekly Resident Food Council meetings provide valuable input for our Culinary department, the hiring of a skilled and experienced Sous Chef that has worked in the Assisted Living industry will complete our Culinary Team. The Bi-Weekly Resident Food Council meeting notes will be reviewed in Lyndale's Quality Assurance meeting and tracked for improvement. Enter methods to incorporate into QA system:

	A binder will be created that will hold inservices related to improving quality of taste, resident food satisfaction or any education relating to the newly formed Resident Food Council Meetings. A Copy of the Resident Food Council Meeting notes will be kept in the binder
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/1/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Rhonda Ogden OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4/21/23

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: kbolino@Lyndalelife.com

August 9, 2023

License Number: AL5525

Kara Bolino, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event 2MU912

Dear Ms. Bolino:

On **August 8, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 6, 2023,** have now been corrected effective **June 1, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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
	AL5525	A. BUILDING: _____ B. WING _____	R-C 08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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 08/08/23. 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