OKLAHOMA
State Department
of Health

Delivery via email to: sslemp@omegasrliving.com

March 6, 2024

License Number: AL5541

Mr. Scott Slemp, Administrator
Teal Creek Assisted Living & Memory Care
13501 N Bryant Ave
Edmond, OK 73013

Survey Event ID: W4LZ11

Dear Mr. Slemp:

On **February 20, 2024,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

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

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

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

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

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face to face, or a virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Teal Creek Assisted Living & Memory Care**
Address: **13501 N Bryant Ave**
City, State, Zip: **Edmond, OK 73013**
Provider #: **AL5541**
Complaint #: **OK00062257**
Investigation Date(s): **February 15th, 16th, & 20th, 2024**

ALLEGATIONS

The center failed to provide care according to the contract and failed to assess, monitor and intervene in a timely manner for a change in condition.
The center failed to ensure the right to use a hospice company of choice and failed to notify the residents' representative of a change of condition.
The center failed to ensure assistance to the bathroom was provided in a timely manner and according to the plan of care.

An unannounced on-site investigation was initiated 02/15/2024 at 4:45 a.m.

A sample of five residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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:

Facility policies were reviewed. Resident admission contracts, service plans, and hospice contracts were reviewed. Resident's clinical records were reviewed. Grievances submitted by residents and family members were reviewed.

Residents were observed to be neat, clean, and well groomed. Staff were observed providing care to residents as needed and according to their plan of care.

Residents, family members, and staff were interviewed.

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: 02/26/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Teal Creek Assisted Living & Memory Care**
Address: **13501 N Bryant Ave**
City, State, Zip: **Edmond, OK 73013**
Provider #: **AL5541**
Complaint #: **OK00062376**
Investigation Date(s): **February 15th, 16th, & 20th, 2024**

ALLEGATIONS

The center failed to ensure adequate supervision was provided to prevent falls and failed to assess, monitor and intervene in a timely manner for falls.
The center failed to ensure residents were not physically, verbally or psychosocially abused.
The center failed to ensure assistance with activities of daily living was provided according to the contract and the plan of care.
The center failed to ensure the right to available communication methods, failed to ensure care was coordinated with hospice care and failed to ensure prompt efforts were made to resolve grievances.
The center failed to ensure adequate and/or competent staff to meet the needs of the residents.
The center failed to have and/or implement an effective infection control program.
The center failed to ensure residents were not admitted who required care and treatment above the level of care the center was equipped to provide.

An unannounced on-site investigation was initiated 02/15/2024 at 4:45 a.m.

A sample of five residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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:

Facility policies were reviewed. Incident reports and grievances were reviewed. Facility documentation of investigations of incidents and grievances were reviewed. Employee files and in-services were reviewed. Facility admission contracts, hospice contracts, and resident service contracts were reviewed. ADL documentation was reviewed. Resident's clinical records were reviewed.

Staff were observed treating residents with dignity and respect. Staff were observed providing care to residents according to their plan of care.

Residents and family members were interviewed. Interviews were completed with administrative, direct care, and support staff.

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: 02/26/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Teal Creek Assisted Living & Memory Care**
Address: **13501 N Bryant Ave**
City, State, Zip: **Edmond, OK 73013**
Provider #: **AL5541**
Complaint #: **OK00062636**
Investigation Date(s): **February 15th, 16th, & 20th, 2024**

ALLEGATIONS

The center failed to ensure residents were not physically, verbally or psychosocially abused

An unannounced on-site investigation was initiated 02/15/2024 at 4:45 a.m.

A sample of five residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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:

Facility policies were reviewed. Incident reports and grievances were reviewed. Facility documentation of investigations of incidents and grievances were reviewed. Employee files and facility inservices were reviewed.

Residents were observed to be neat, clean, and well groomed. Staff were observed treating residents with dignity and respect.

Residents, family members, and staff were interviewed.

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: 02/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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 Complaint investigations (#OK00062636, OK00062257, and #OK00062376) were conducted on 02/15/24, 02/16/24, and 02/20/24. Facility Census: 81 Listed below are abbreviations that will be used throughout this document. cap (s) - capsule (s) g - gram LPN - Licensed Practical Nurse mcg - microgram mg - milligrams OTC - over the counter tabs - tablets VA - Veteran's Administration vit - vitamin	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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,	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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
C1505	Continued From page 1 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 record review, observation, and interview, the facility failed to ensure that residents were assessed for their ability to safely self-administer medications for three (#1, 6, and #7) of four sampled residents observed with over the counter and prescription medications in their possession for self-administration. The administrator identified 81 residents resided in the facility. Findings: A "Medications & Treatment - Self-Administration of Medication" policy, undated, read in part, " ...If a resident desires to self-administer medications, an evaluation should be conducted by the Nurse, or designee of the resident's cognitive, physical, and visual ability to carry this out ..."	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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
C1505	Continued From page 2 1. Resident #6 had diagnoses that included Alzheimer's and dementia with anxiety. On 02/15/24 at 5:00 a.m., Resident #6 was observed in their room in bed. Opened packages of Mood Probiotic, Calm Aid, and Afrin Nasal Spray were observed on the counter in the room. CNA #1 was present and stated she did not know if the resident self-administered these medications. There was no documentation in the clinical record that an assessment to self-administer medications had been completed for Resident #6. 2. Resident #7 had diagnoses that included senile degeneration of the brain and vascular dementia (severe) with mood disturbance. On 02/15/24 at 5:00 a.m., Resident #7 was observed in their room in bed. Opened packages of Mood Probiotic, Calm Aid, and Afrin Nasal Spray were observed on the counter in the room. CNA #1 was present and stated she did not know if the resident self-administered these medications. There was no documentation in the clinical record that an assessment to self-administer medications had been completed for Resident #7. 3. Resident #1 had diagnoses that included glaucoma with blindness and multiple sclerosis. On 02/15/24 at 10:20 a.m., Resident #1 was observed in their room up in wheelchair removing several containers of medications from their bed and putting them into a blue purse. Resident #1 was asked if they self-administered these	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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
C1505	Continued From page 3 medications. They stated yes and asked this surveyor to return later to get a list of the medications. On 02/16/24 at 5:00 p.m., Resident #1 was observed to have in their possession the following prescription medications from the VA pharmacy: Prenatal Vitamins, Methocarbamol 500mg tabs, Furosemide 20mg tabs, Sennosides 8.6mg tabs, Docusate 100mg caps, Diclofenac Topical Gel 1%, Gabapentin 100mg caps, and MiraLAX Powder 17g/cap. They also had in their possession the following OTC medications: Extra Strength Vit D3 125mcg caps, Refresher Eye Gel, and Melatonin lozenges. There was no documentation in the clinical record that an assessment to self-administer medications had been completed for Resident #1. On 02/16/24 at 5:07 p.m., LPN #1 was asked the facility policy on allowing residents to self-administer medications. They stated, "We give them a questionnaire and they have to be able to answer and then demonstrate." LPN # 1 was asked if any residents in the facility currently self-administered medications. They stated not at this time. LPN #1 was made aware of the above observations for Resident #1, #6, and #7 and was asked if they had been assessed for their ability to safely self-administer medications. LPN #1 stated they had not and acknowledged the facility policy had not been followed.	C1505		

OKLAHOMA
State Department of Health

Delivery via email to: sslemp@omegasrliving.com

March 13, 2024

License Number: AL5541

Mr. Scott Slemp, Administrator
Teal Creek Assisted Living & Memory Care
13501 N Bryant Ave
Edmond, OK 73013

Survey Event ID: W4LZ11

Dear Mr. Slemp:

On **February 20, 2024,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 19, 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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/11/2024** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** W4LZ11 **Date Survey Completed: 2/20/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: record review, observation, and interview, the facility failed to ensure that residents were assessed for their ability to safely self-administer medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The facility does not admit guilt to any deficient practice.

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?	Health and Wellness Director or their designee will check all rooms for medications in room.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Health and Wellness Director or their designee will check all rooms for medication in rooms.
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?	Health and Wellness Director will do monthly random room audits for 3 months and report findings to QA Committee. Health and Wellness Director will be in-serviced on self-administration policy and self-aministration assessment.
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.	Health and Wellness Director will report audits findings with recommendations to QA Committee. QA Commiittee will evaluate findings and recommendations. Health and Wellness Director will give recommendations to QA Committee QA Committee will review monthly
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/19/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	**Date 3/11/2024**

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

Delivery via email to: Scott Slemp <sslemp@omegasrliving.com>

April 26, 2024

License Number: AL5541

Mr. Scott Slemp, Administrator
Teal Creek Assisted Living & Memory Care
13501 N Bryant Ave
Edmond, OK 73013

Survey Event ID: W4LZ12

Dear Mr. Slemp:

On **April 24, 2024,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **February 20, 2024,** have now been corrected effective **April 19, 2024.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	R-C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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 revisit was conducted from 04/24/24. All deficiencies from the 02/20/24 survey were cleared. Facility Census: 95	{C 000}		

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