OKLAHOMA
State Department
of Health

Delivery via email to: rebecca.ramos@irisseniorliving.com

January 8, 2026

License Number: AL5547

Ms. Rebecca Ramos, Administrator
Iris Memory Care Of Edmond
2424 Nw 178th St
Edmond, OK 73012

Survey Event ID: H8ZC11

Dear Ms. Ramos:

On **December 29, 2025,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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,

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: **IRIS MEMORY CARE OF EDMOND**
Address: **2424 NW 178TH ST**
City, State, Zip: **EDMOND, OK 73012**
Provider #: **AL5547**
Complaint #: **OK00087850**
Investigation Date(s): **12/23/25, 12/26/25, and 12/29/25**

ALLEGATION(S)
The center failed to assess, monitor, and/or intervene when a resident had a change in condition.
The center failed to ensure staffing to meet the needs of the residents

An unannounced on-site investigation was initiated 12/23/2025 at 10:36 a.m.

A sample of three 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:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Staff on duty were observed. Residents were observed for a change in condition and accident hazards.

Facility policy and procedures were reviewed. Nurses' notes, provider progress notes, physician orders, care plans, service plans, resident contracts, hospital records, resident assessments, and State reportables were reviewed. Staff schedules were reviewed.

Residents and/or representatives were interviewed regarding changes in condition and staffing. Staff were interviewed regarding the facility policies and procedures related to changes in condition and staffing.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5547	A. BUILDING: _____ B. WING _____	C 12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS MEMORY CARE OF EDMOND	2424 NW 178TH ST EDMOND, OK 73012

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C 000	INITIAL COMMENTS A complaint investigation (#OK00087850) was conducted on 12/23/25, 12/26/25, and 12/29/25. Deficiencies were cited as a result of the survey. Facility Census: 38 Listed below are abbreviations that will be used throughout this document. CNA- certified nurse aide DON- director of nursing	C 000		
C1505 SS=D	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, 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.	C1505		

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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to provide timely assistance after a fall for 1 (#2) of 3 sampled residents reviewed for adequate staffing.

The DON identified 38 residents resided in the facility.

Findings:

An undated facility "FALL RESPONSE" policy, read in part, "Always communicate with the Resident and ask if he/she is in any pain and, if so, the location of pain. Take vitals signs"..."If the Resident is unable to stand with minimal or no assistance, do not attempt to assist the Resident to his/her feet without assistance from another individual"..."If no no other IRIS Team Member is in IRIS, contact the ED [executive director], WD [wellness director] or designee for direction as to who to call for assistance in moving the fallen Resident. Do not, unless absolutely necessary, leave the Resident alone until emergency assistance arrives"..."Once help has been secured, calm other residents, if necessary."

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C1505	Continued From page 3	C1505		

they needed help. The unidentified resident left Resident #2's room,
g. 6:20 a.m., the unidentified resident walked back into Resident #2's room and informed the Resident #2 staff was coming. CNA #1 walked in moments later and escorted the unidentified resident out of the room. CNA #1 attempted to put Resident #2 in a sitting position. They checked the resident's buttocks area and the resident told them they already, "Done that,"
h. 6:21 a.m., CNA #1 walked out of the resident's room. Resident #2 remained on the floor, and
i. 6:24 a.m., CNA #1 and CNA #2 entered Resident #2's room. They provided incontinent care and assisted the resident to a sitting position on the side of the bed.

On 12/26/25 at 10:21 a.m., the administrator stated CNA #2 no longer worked at the facility.

On 12/26/25 at 12:56 p.m., CNA #1 stated if a resident fell, they were to call the medication aide and depending on the fall, they were to leave the resident on the floor. They stated if the medication aide was not available, they were to call the DON.

On 12/26/25 at 12:59 p.m., CNA #1 stated Resident #2's fall incident occurred around the time they got residents up in the morning. They stated it could be around 5:30 a.m. CNA #1 stated they heard the bed alarm and went to check on the resident. They stated the resident had a fall. CNA #1 stated they were the only staff working in building B, so they called to let the DON know because the resident required two person assistance. CNA #1 stated the DON called for assistance from building A.

On 12/26/25 at 1:02 p.m., CNA #1 stated when

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C1505	Continued From page 4	C1505		

the resident screamed, they could hear it while in building B especially when it was quiet at night.

On 12/26/25 at 1:06 p.m., CNA #1 stated after leaving the resident's room around 6:00 a.m., they continued to communicate with the DON to get help. They stated they had left another resident sitting on a toilet to check Resident #2, so they went back to the resident to complete care. They stated they continued to get other residents up while waiting for help from building A.

On 12/26/25 at 1:09 p.m., CNA #1 stated another resident had entered Resident #2's room so they redirected them out of the resident's room. They stated they walked up and down the hall.

On 12/26/25 at 1:12 p.m., CNA #1 stated it was not acceptable to leave the resident without assistance after a fall.

On 12/26/25 at 1:13 p.m., CNA #1 stated almost all the residents in building B at that time required some sort of assistance with activities of daily living. They stated CNA #2 no longer worked at the facility.

On 12/26/25 at 1:23 p.m., the DON stated CNA #1 had called them and they called staff in building B for assistance. They stated the staff in building B were changing a resident who required two person assistance. The DON stated the expectation of the CNA who found the resident was to position the resident for comfort and keep an eye on them.

On 12/26/25 at 1:31 p.m., the staffing coordinator stated building B was staffed with one aide and building A had two aides on the night shift.

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C1505	Continued From page 5 On 12/29/25 at 11:55 a.m., the DON stated they expected staff to keep an eye on the resident and stay with them while waiting for help, but the staff had responsibilities of other residents. On 12/29/25 at 11:58 a.m., the DON was asked what other interventions the facility could had implemented while waiting for assistance. They stated they could had call emergency services for lifting assistance. The DON stated the facility did not call emergency services.	C1505		

OKLAHOMA
State Department of Health

Delivery via email to: rebecca.ramos@irisseniorliving.com

January 16, 2026

License Number: AL5547

Ms. Rebecca Ramos, Administrator
Iris Memory Care Of Edmond
2424 Nw 178th St
Edmond, OK 73012

Survey Event ID: H8ZC11

Dear Ms. Ramos:

On **December 29, 2025,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and in a timely manner. **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 **January 26, 2026**.

We will conduct a revisit 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

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Signed by:
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonna Warrick
8895EF3A971D405...
TITLE: Regional Director of Operations
(X6) DATE: 1/15/2026

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The DON identified 38 residents resided in the facility.

Findings:

An undated facility "FALL RESPONSE" policy, read in part, "Always communicate with the Resident and ask if he/she is in any pain and, if so, the location of pain. Take vitals signs"..."If the Resident is unable to stand with minimal or no assistance, do not attempt to assist the Resident to his/her feet without assistance from another individual"..."If no no other IRIS Team Member is in IRIS, contact the ED [executive director], WD [wellness director] or designee for direction as to who to call for assistance in moving the fallen Resident. Do not, unless absolutely necessary, leave the Resident alone until emergency assistance arrives"..."Once help has been secured, calm other residents, if necessary."

1. Corrective Action Taken: 12.30.25

   At the time the complaint investigation and deficiency were identified, Resident #2 was no longer residing at Iris Memory Care of Edmond. Therefore, no direct corrective action could be implemented for the individual resident. The incident was reviewed internally by nursing leadership to identify opportunities for improvement related to fall response, supervision, staffing escalation, and resident rights. Findings from this review were incorporated into staff education and process improvements.

2. How Others were protected: 1.15.26

   The Director of Nursing or designee completed a facility-wide review of residents with a history of falls, two-person assist needs, or cognitive impairment affecting safety awareness. A 90-day fall review was conducted to verify timely responses, post-fall supervision, and appropriate escalation. Identified gaps were immediately corrected.

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C1505	Continued From page 3	C1505		

they needed help. The unidentified resident left Resident #2's room,
g. 6:20 a.m., the unidentified resident walked back into Resident #2's room and informed the Resident #2 staff was coming. CNA #1 walked in moments later and escorted the unidentified resident out of the room. CNA #1 attempted to put Resident #2 in a sitting position. They checked the resident's buttocks area and the resident told them they already, "Done that,"
h. 6:21 a.m., CNA #1 walked out of the resident's room. Resident #2 remained on the floor, and
i. 6:24 a.m., CNA #1 and CNA #2 entered Resident #2's room. They provided incontinent care and assisted the resident to a sitting position on the side of the bed.

On 12/26/25 at 10:21 a.m., the administrator stated CNA #2 no longer worked at the facility.

On 12/26/25 at 12:56 p.m., CNA #1 stated if a resident fell, they were to call the medication aide and depending on the fall, they were to leave the resident on the floor. They stated if the medication aide was not available, they were to call the DON.

On 12/26/25 at 12:59 p.m., CNA #1 stated Resident #2's fall incident occurred around the time they got residents up in the morning. They stated it could be around 5:30 a.m. CNA #1 stated they heard the bed alarm and went to check on the resident. They stated the resident had a fall. CNA #1 stated they were the only staff working in building B, so they called to let the DON know because the resident required two person assistance. CNA #1 stated the DON called for assistance from building A.

On 12/26/25 at 1:02 p.m., CNA #1 stated when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5547	A. BUILDING: _____ B. WING _____	C 12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS MEMORY CARE OF EDMOND	2424 NW 178TH ST EDMOND, OK 73012

(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 4	C1505		

the resident screamed, they could hear it while in building B especially when it was quiet at night.

On 12/26/25 at 1:06 p.m., CNA #1 stated after leaving the resident's room around 6:00 a.m., they continued to communicate with the DON to get help. They stated they had left another resident sitting on a toilet to check Resident #2, so they went back to the resident to complete care. They stated they continued to get other residents up while waiting for help from building A.

On 12/26/25 at 1:09 p.m., CNA #1 stated another resident had entered Resident #2's room so they redirected them out of the resident's room. They stated they walked up and down the hall.

On 12/26/25 at 1:12 p.m., CNA #1 stated it was not acceptable to leave the resident without assistance after a fall.

On 12/26/25 at 1:13 p.m., CNA #1 stated almost all the residents in building B at that time required some sort of assistance with activities of daily living. They stated CNA #2 no longer worked at the facility.

On 12/26/25 at 1:23 p.m., the DON stated CNA #1 had called them and they called staff in building B for assistance. They stated the staff in building B were changing a resident who required two person assistance. The DON stated the expectation of the CNA who found the resident was to position the resident for comfort and keep an eye on them.

On 12/26/25 at 1:31 p.m., the staffing coordinator stated building B was staffed with one aide and building A had two aides on the night shift.

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	AL5547	A. BUILDING: _____ B. WING _____	C 12/29/2025

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IRIS MEMORY CARE OF EDMOND	2424 NW 178TH ST EDMOND, OK 73012

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C1505	Continued From page 5 On 12/29/25 at 11:55 a.m., the DON stated they expected staff to keep an eye on the resident and stay with them while waiting for help, but the staff had responsibilities of other residents. On 12/29/25 at 11:58 a.m., the DON was asked what other interventions the facility could had implemented while waiting for assistance. They stated they could had call emergency services for lifting assistance. The DON stated the facility did not call emergency services.	C1505		

Iris Memory Care – POC Audit Summary & QA Attestation

Community: _____ POC Tag(s): _____

POC Start Date: _____ POC Completion Date: _____

Weekly Post-POC Monitoring (30 Days)

- ■ Week 1 Audit Completed Date: _____ Auditor Initials: _____
- ■ Week 2 Audit Completed Date: _____ Auditor Initials: _____
- ■ Week 3 Audit Completed Date: _____ Auditor Initials: _____
- ■ Week 4 Audit Completed Date: _____ Auditor Initials: _____

Monthly Post-POC Monitoring

- ■ Month 1 Audit Completed Date: _____ Auditor Initials: _____
- ■ Month 2 Audit Completed Date: _____ Auditor Initials: _____
- ■ Month 3 Audit Completed Date: _____ Auditor Initials: _____

Quality Assurance Review

- ■ QA Review Completed and Monitoring Sustained

Summary of Findings / Improvements:

Leadership Attestation

I attest that the above monitoring was completed as outlined in the Plan of Correction and that corrective actions were implemented and sustained.

Director of Nursing Signature: _____ Date: _____

Executive Director Signature: _____ Date: _____

Internal QA document – maintained with Plan of Correction for regulatory compliance.

Fall Meeting

Monthly: _____

Total Of Falls: _____

Days # _____ Evenings # _____ Overnights # _____

Number of repeat falls _____

Resident Names of repeat falls

Name	# of repeat falls	Days	Evenings	Overnights

[ ] Resident was not left unattended after the fall

[ ] Staff remained with the resident until assistance arrived

[ ] Appropriate staff escalation occurred

Any Trends? Yes No

If there is a trend noted, what is it?

Resolution to resolving the trend

_____
_____
_____
_____

Attendees:

_____ _____
_____

_____ _____
_____

This is a internal tracking sheet used for the sole purpose of QA.

Fall Response – Staff Education & Reinforcement

This education is being provided to reinforce Iris Memory Care's Fall Response Policy and to ensure all staff clearly understand expectations related to resident safety, resident rights, and emergency response following a fall.

Key Policy Reinforcements
• Residents must NEVER be left unattended after a fall.
• ALL falls are to be considered EMERGENT situations.
• Routine care tasks must STOP immediately until the emergent situation is fully resolved.

Definition of an Emergent Situation
An emergent situation is any event that places a resident at immediate risk of harm or injury and requires prompt staff intervention. Effective immediately, any resident fall is defined as an EMERGENT situation. Emergent situations take priority over all other tasks, including routine care, toileting, documentation, or other resident needs.

Fall Response Expectations
When a fall occurs, staff are expected to:
• Stay with the resident at all times until assistance arrives
• Call for additional staff support immediately
• Escalate to nursing leadership without delay
• Complete incident report per policy
• Ensure appropriate notification of family and third-party providers are completed

Resident Rights
Residents have the right to receive adequate and appropriate medical care. Leaving a resident unattended after a fall violates the resident's rights and places the resident at risk. Staff are expected to prioritize resident dignity, safety, and comfort at all times.

Staffing & Escalation
Overnight staffing patterns and contingency plans have been reviewed. All staff must follow established escalation procedures when additional assistance is needed. Lack of staffing does not remove the obligation to remain with a resident following a fall.

Accountability
All staff received mandatory re-education on fall response, resident rights, and escalation expectations. Failure to follow these expectations will result in corrective action in accordance with Iris Memory Care policy, up to and including termination.

Fall Meeting

Week: _____

Total Of Falls: _____

Days # _____ Evenings # _____ Overnights # _____

Number of repeat falls _____

Resident Names of repeat falls

Name	# of repeat falls	Days	Evenings	Overnights

[ ] Resident was not left unattended after the fall

[ ] Staff remained with the resident until assistance arrived

[ ] Appropriate staff escalation occurred

Any Trends? Yes No

If there is a trend noted, what is it?

Resolution to resolving the trend

_____
_____
_____
_____

Attendees:

_____ _____
_____

_____ _____
_____

This is a internal tracking sheet used for the sole purpose of QA.

OKLAHOMA
State Department of Health

Delivery via email to: rebecca.ramos@irisseniorliving.com

January 28, 2026

License Number: AL5547

Ms. Jonna Warrick, Administrator
Iris Memory Care Of Edmond
2424 Nw 178th St
Edmond, OK 73012

RE: Survey Event H8ZC12

Dear Ms. Warrick:

On **January 28, 2026,** an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 29, 2025,** have now been corrected effective **January 26, 2026.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5547	A. BUILDING: _____ B. WING _____	R-C 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 01/28/26. 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