OKLAHOMA
State Department
of Health

Delivery via email to: tscheer@ada.baptistvillage.org

May 22, 2024

License Number: AL6203

Ms. Tracy Scheer, Administrator
The Neighborhoods At Baptist Village Of Ada
3501 Oakridge Drive
Ada, OK 74820

RE: Survey Event ID: WHGI11

Dear Ms. Scheer:

On **May 16, 2024**, agents from our office concluded a State Relicensure 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 **May 16, 2024**.

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

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

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

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

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

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6203	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BAPTIST VILLAGE	3501 OAKRIDGE DRIVE ADA, OK 74820

(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 on 05/14/24 and 05/16/24. Facility Census: 21 The below abbreviations are used throughout the document: DON - director of nursing OSDH - Oklahoma State Department of Health Res - resident	C 000		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital;	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6203	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BAPTIST VILLAGE	3501 OAKRIDGE DRIVE ADA, OK 74820

(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
C1912	Continued From page 1 (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to submit an incident report to OSDH for an incident resulting in serious injury for one (#4) of eight sampled residents reviewed for comprehensive chart review. The DON identified 21 residents resided in the facility. Findings: Res #4 had diagnoses which included osteoporosis. An internal incident report, dated 05/02/24, documented Res #4 had a fall in their apartment resulting in pain to the right leg and subsequent transfer to the hospital. A progress note, dated 05/03/24, documented	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6203	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BAPTIST VILLAGE	3501 OAKRIDGE DRIVE ADA, OK 74820

(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
C1912	Continued From page 2 Res #4 had a broken hip and was scheduled for surgery the next day. A record review did not document an incident report was submitted to OSDH related to the fall with fracture. On 05/16/24 at 11:22 a.m. the DON stated they did not send a report to the department. They stated they missed it because they were not informed of the serious injury until the next day. They stated the report should have been submitted to the department within one business day of the notification of injury.	C1912		

OKLAHOMA
State Department
of Health

Delivery via email to: tscheer@ada.baptistvillage.org

June 17, 2024

License Number: AL6203

Ms. Tracy Scheer, Administrator
The Neighborhoods At Baptist Village Of Ada
3501 Oakridge Drive
Ada, OK 74820

RE: Survey Event WHGI11

Dear Ms. Scheer:

On **May 16, 2024**, a Relicensure 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 30, 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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6203	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BAPTIST VILLAGE	3501 OAKRIDGE DRIVE ADA, OK 74820

(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 on 05/14/24 and 05/16/24. Facility Census: 21 The below abbreviations are used throughout the document: DON - director of nursing OSDH - Oklahoma State Department of Health Res - resident	C 000	Plan of Correction is being submitted with optional template.	
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital;	C1912		

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
	AL6203	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BAPTIST VILLAGE	3501 OAKRIDGE DRIVE ADA, OK 74820

(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
C1912	Continued From page 1 (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to submit an incident report to OSDH for an incident resulting in serious injury for one (#4) of eight sampled residents reviewed for comprehensive chart review. The DON identified 21 residents resided in the facility. Findings: Res #4 had diagnoses which included osteoporosis. An internal incident report, dated 05/02/24, documented Res #4 had a fall in their apartment resulting in pain to the right leg and subsequent transfer to the hospital. A progress note, dated 05/03/24, documented	C1912	Plan of Correction is being submitted with optional template.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6203	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BAPTIST VILLAGE	3501 OAKRIDGE DRIVE ADA, OK 74820

(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
C1912	Continued From page 2 Res #4 had a broken hip and was scheduled for surgery the next day. A record review did not document an incident report was submitted to OSDH related to the fall with fracture. On 05/16/24 at 11:22 a.m. the DON stated they did not send a report to the department. They stated they missed it because they were not informed of the serious injury until the next day. They stated the report should have been submitted to the department within one business day of the notification of injury.	C1912	Plan of Correction is being submitted with optional template.	

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 5/30/2024
	Facility Name: Baptist Village of Ada
	License Number: AL 6203
	Survey Event ID: WHGI11
	Date Survey Completed: 5/16/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1912	Based on: Based on record review and interview, the facilityfailed to submit an incident report to OSDH for anincident resulting in serious injury for one (#4) ofeight sampled residents reviewed forcomprehensive chart review.The DON identified 21 residents resided in thefacility.Findings:Res #4 had diagnoses which includedosteoporosis.An internal incident report, dated 05/02/24,documented Res #4 had a fall in their apartmentresulting in pain to the right leg and subsequenttransfer to the hospital.A progress note, dated 05/03/24, documented. Res #4 had a broken hip and was scheduled forsurgery the next day.A record review did not document an incidentreport was submitted to OSDH related to the fallwith fracture.On 05/16/24 at 11:22 a.m. the DON stated theydid not send a report to the department. Theystated they missed it because they were notinformed of the serious injury until the next day.They stated the report should have beensubmitted to the department within one businessday of the notification of injury.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is being submitted pursuant to applicable state and federal regulations. Nothing contained herein shall be construed as an admission that the facility failed to follow any applicable standard of care.

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 incident report to OSDH for the incident dated 05/02/24 for resident #4 of the sample was completed and faxed to OSDH on 5/16/2024 immediately after discovery that it was not completed; the fax was confirmed. The administrator has conducted an in-service training of nursing staff to review the regulatory requirements outlined in section 3120:663-19-1(b) for incident reporting. Nursing training emphasized the importance of incident reporting, and that all residents must be included, even when they are being treated by outside providers. This training was completed on 5-30-2024 with all nursing staff attending.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DOHS and RN consultant have performed a review of all resident charts to identify any incidents that require OSDH reporting. Any incidents discovered that require OSDH reporting were reported per regulation and the faxes were confirmed. DOHS and RN consultant have documented the results of their review of resident charts on a log sheet.
OSDH Response: Element accepted Yes ☐ No ☐	

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The administrator has implemented new protocols for handling incidents. Per the new protocol, the administrator will be notified by nursing staff of all incidents immediately after the occur. Nursing staff will discuss all incidents with the administrator with the understanding that all incidents are considered reportable to OSDH unless the nursing staff can justify to the administrator that reporting is not required. Nursing staff will complete any required reporting to OSDH. Nursing staff will provide the date and time that the OSDH report was confirmed to the administrator. The administrator will verify that incident reports to OSDH are by visualizing the report and fax confirmation sheet. The administrator will sign a log after verifying each OSDH report completion.
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.	Corrections will be sustained by implementing a new procedure for how to handle incidents, incorporating the corrective action into the facility's QA program and by ongoing monitoring and oversight at multiple levels including DOHS, RN consultant, administrator and Director of Quality. The correction will be evaluated for effectiveness per the following observations: a.The administrator will verify that incident reports to OSDH are completed by visualizing the report and fax confirmation sheet stored in the incident report binder after they have been completed. b.Incident reviews will be added to the monthly compliance audit completed by the administrator to verify there is no missed reporting to OSDH. The correction will be incorporated into the facility's quality assurance program by: a.The QA team will monitor and document progress during quarterly meetings. b.The Director of Quality will review both internal and OSDH incident reports quarterly for compliance The following records will be kept for monitoring evidence of the correction: • Copy nursing staff training content with sign-in sheet • Resident roster with signature of DOHS or RN consult indicating that they have reviewed the chart for incidents and the results (none found, one corrected, etc…) and copies of any 283 reports send due to this audit .• Copy of the new written protocol for handling

	incidents • Copy of log with administrator signatures obtained after verifying OSDH report completion and copies of any 283s done since date of survey with fax confirmation sheets
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.	**Date** Enter a date of signature. 5-30-24

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

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

Items Below Are For OSDH Use Only

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

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

OKLAHOMA
State Department
of Health

Delivery via email to: tscheer@ada.baptistvillage.org

August 27, 2024

License Number: AL6203
Survey Event ID: WHGI12

Ms. Tracy Scheer, Administrator
The Neighborhoods At Baptist Village Of Ada
3501 Oakridge Drive
Ada, OK 74820

Dear Ms. Scheer:

On **August 27, 2024**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **May 16, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **May 30, 2024**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6203	A. BUILDING: _____ B. WING _____	R 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BAPTIST VILLAGE	3501 OAKRIDGE DRIVE ADA, OK 74820

(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 On 08/27/24, an offsite/revisit was conducted. The deficiencies from 05/16/24 were cleared.	{C 000}		

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