OKLAHOMA
State Department
of Health

Delivery via email to: MichelleN@knownmemorycare.com

July 26, 2023

License Number: AL7238

Ms. Michelle Netters, Administrator
Known Memory Care
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event ID: P6Z211

Dear Ms. Netters:

On **June 21, 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 June 21, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOWN MEMORY CARE	7807 S MINGO RD TULSA, OK 74133

(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 06/20/23 through 06/21/23.	C 000		
C 391 SS=E	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, record review, and interview, the facility failed to maintain the dish machine sanitation according to manufacturer's minimum requirements. The administrator identified 30 residents who received nutrients from the kitchen. Findings: The manufacturer's minimum requirements label, located on the facility dish machine, documented the dispensed chemical sanitizing agent level was to measure at a minimum of 50 parts per million. On 06/20/23 at 1:00 p.m., the dish machine temperature log was reviewed for the dates of 04/18/23 through 06/19/23. The dish machine temperature log documented the chemical sanitizing agent level ranged from 110 to 125 parts per million. On 06/20/23 at 1:00 p.m., Cook #1 was asked to check the concentration of sanitizing agent for the dish machine. Cook ran the dish machine and waited for the rinse cycle to start. The cook observed the temperature gauge on the dish	C 391		

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C 391	Continued From page 1 machine and stated it was just under 120 degree Fahrenheit. On 06/20/23 at 1:02 p.m., Cook #2 was asked how to check the concentration of sanitizing agent. Cook #2 stated they documented what the temperature gauge read during the rinse cycle as the level of sanitizing agent. On 06/20/23 at 1:05 p.m., the test strips were located and Cook #2 measured the concentration of the sanitizing agent of the dish machine. The testing strip did not change color. The testing strip was compared to the control listed on the side of the container housing the testing strips. The control documented sample colors for 10 parts per million of sanitizing agent (faint blue), 50 parts per million of sanitizing agent (light blue), 100 parts per million of sanitizing agent (medium blue), and 200 parts per million of sanitizing agent (dark blue). There was no change in the color of the test strip. On 06/20/23 at 1:07 p.m., Cook #1 and Cook #2 were both asked what the test strip indicated was the level of the sanitizing agent. Both cooks stated they did not know how to check the level of sanitizing agent on the dish machine or read the test strip.	C 391		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		

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	AL7238	A. BUILDING: _____ B. WING _____	06/21/2023

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KNOWN MEMORY CARE	7807 S MINGO RD TULSA, OK 74133

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C 954	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff received CPR and first aid training for one (CNA #1) of five sampled staff reviewed for CPR and first aid training. The "Assisted Living Resident Condition and Care Overview," dated 06/20/23, documented 30 residents. Findings: CNA#1 had a date of hire of 05/26/23. No documentation was provided of training in CPR or first aid. On 06/21/23 at 2:31 p.m. the administration was asked if the staff had CPR or first aid training. They stated they didn't realize it was a requirement.	C 954		
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to administer	C1920		

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	AL7238	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOWN MEMORY CARE	7807 S MINGO RD TULSA, OK 74133

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C1920	Continued From page 3	C1920		

medications per physician's orders and standards of practice for two (#5 and #6) of seven sampled residents observed during a medication pass. The medication error rate was 10 percent.

The "Assisted Living Resident Condition and Care Overview", dated 06/20/23, documented 30 residents.

Findings:

The FDA website, www.accessdata.fda.gov, documented metoprolol succinate extended release tablets may cause bradycardia and shortness of breath. The website also documented in part, "...Metoprolol succinate extended-release tablets are scored and can be divided; however, the whole or half tablet should be swallowed whole and not chewed or crushed..."

The FDA website, www.accessdata.fda.gov, documented in part,"...Patients should be cautioned that PROTONIX [pantoprazole] Delayed-Release Tablets and PROTONIX For Delayed-Release Oral Suspension should not be split, chewed, or crushed..."

1. Resident #5 had diagnoses which included bradycardia.

On 06/21/23 at 8:20 a.m., CMA #1 was observed to administer medications to resident #5. CMA #1 crushed the metoprolol succinate, a long acting, enteric coated, cardiac medication.

2. Resident #6 had diagnoses which included anxiety and fluid retention.

The physician's order, dated 04/13/23,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOWN MEMORY CARE	7807 S MINGO RD TULSA, OK 74133

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C1920	Continued From page 4	C1920		

documented the resident was to receive pantoprazole (Protonix) 20mg delayed release tablet once daily.

The physician's order, dated 05/23/23, documented the resident was to receive furosemide 20mg twice daily. The order documented to monitor the resident's blood pressure and hold the medication if the blood pressure was less than 100/60.

On 06/21/23 at 8:30 a.m., CMA #1 was observed to administer medications to resident #6.

CMA #1 crushed the pantoprazole, a long acting enteric coated proton pump inhibitor used to decrease gastric acids.

CMA #1 also administered furosemide 20mg without first obtaining the resident's blood pressure. The physician's order documented to hold the furosemide if the resident's blood pressure was below 100/60.

On 06/21/23 at 08:32 a.m., CMA #1 was asked what the blood pressure reading was for resident #6. They stated the resident was not on their list to get a blood pressure.

CMA #1 was informed of the above observations for resident #5 and resident #6. The CMA stated they were new to the position.

On 06/21/23 at 10:00 a.m., the Clinical Executive Director was informed of the medication observation pass and medication error rate. The Clinical Executive Director stated the metoprolol succinate and pantoprazole should not have been crushed and the blood pressure should have been checked prior to the administration of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	06/21/2023

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C1920	Continued From page 5 furosemide.	C1920		

OKLAHOMA
State Department
of Health

Delivery via email to: RachelR@knownmemorycare.com

August 14, 2023

License Number: AL7238

Ms. Rachel Ray, Administrator
Known Memory Care
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event P6Z211

Dear Ms. Ray:

On **June 21, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 22, 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

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/4/2023** **Facility Name:** Known Memory Care **License Number:** AL7238 **Survey Event ID:** P6Z211 **Date Survey Completed: 6/21/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391/SSE	Based on: Record review and interview the facility failed to maintain the dish machine sanitation according to manufacturer's minimum requirements.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The current dishwasher will be replaced and the 3 sink dish washing was put in place immediately upon state surveryors viist.

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?	As of 6-21-2023 The 3 sink wash was initiated. Maintenance was notified and came out to look at dishwasher it was determined due to cost of fixing that a new dishwasher was the best alternative . Dishwasher will not be used until replaced with a new dishwasher
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Nurse and Dr Brown saw residents no residents showing any signs or symptons of nausea or loose stools or any signs of being sick d/t failure of sanitation on dishwasher
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?	Dishwasher will be replaced with a functioning dish washer that test accurately with sanitation requirements.
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.	A. ED/BOM and kitchen associates will monitor daily and ensure that the 3 sink wash will be used and Dish washer will not be used until replaced. B. ED will QA and review in next QA meeting. New diswahser and washing in 3 sinks until replacement with new dishwasher C. QA check off will be put in place for the kitchen staff that the 3 sink wash was done and the ED will monitor daily with check off list that the 3 sink dish wash is appropriately being done and ensure that the dish washer is not used daily until replacement of new dishwasher. ED will monitor and QA daily check off list in kitchen daily until new dishwasher is in place.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/22/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Rachel Ray ED** Rachel Ray ED. OAC 310:663-25-4(F)	**Date 8/4/2023**

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: 8/4/2023

Facility Name: Known Memory Care Assisted Living

License Number: AL-7238

Survey Event ID: P6Z211

Date Survey Completed: 6/21/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954 / SS=D	Based on: the record and review the facility failed to ensure direct care staff received CPR and first aide trainingfor one (CAN #1) of five sampled staff reviewed for CPR and first aid training.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Direct Care staff will be trained for CPR and First Aid now and then upon hire and annually

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?	No residents were noted to be affected by any associates not having training for CPR and First Aide.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Direct Care staff training began 6-29-2023 for CPR and First Aid training,
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?	Direct Care Staff will be given training and tested for CPR and First Aide training upon hire and annually.
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.	A. ED and designee will initiate a QA hiring check off list that includes new hires completing CPR and First Aide Training upon hire and annually . We will also ensure that when annual performance given that training for CPR and First aide will be included. B. ED wiill QA all new hires and check off list to ensure that all new hires are trained for CPR and First Aide. C. The check off list will be included in the quartley QA meeting and discussion regarding the importance of training for CPR and First aide and to check the check off list to ensure all new hires and annually they are completing training. D.ED will monitor upon onboarding new hires and the ED will monitor completion upon yearly annual
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/22/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Rachel Ray ED** Rachel Ray ED — **Date 8/4/2023**

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: 8/4/2023** **Facility Name:** Known Memory Care Assisted living **License Number:** AL-7238 **Survey Event ID:** P6Z211 **Date Survey Completed: 6/22/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1920 SS=E	Based on: observation ,record review, and interview, the facility failed to administer medications per the physcian's orders and standards of practice for two (# 5 and # 6) of seven sampled residents observed during a medication pass, The medication rate was 10 percent.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Medication Aides will have more education in insevices related to passing medications accurately and receive more education of the understanding of following DR. Orders.

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 residents affected by the deficient practice will be monitored to ensure that there medications are not crushable medications will not be crushed and that the blood pressures will be taken prior to given medications and Dr. orders with parameters will be followed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	29 Residents audited and QA'd to ensure that only medicaions being crushed are appropriate FDA approved and monitoring there blood pressure to ensure that the permamiters are being followed per the Dr's orders.
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?	List of crushable medications placed in front of medication book along with one posted in medication room. Larger laptop where medication aides can google for more education on crushable medications. Inservice held for CMA's by pharmacist 8-7-2023 regarding importance of following Dr. Orders and B/P parameters, cart audit by pharmacist completed 7-31-2023. Will continue with follow up education on medication passes and will be doing random cart audits as well. Nurse will be doing a audit and obtain Dr. orders to change to liquid if medications are difficult to swallow and need crushing.
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.	A. Medication Aides will be monitored daily for efficiency giving medications that require taking b/p and following Dr. orders to hold b/p if parameters are lower then order prior to given medicaion. Nurse will monitor and audit daily for crush medications that are crushable per the FDA website. B. Medication aides will be audited and monitored daily x 2 weeks then weekly x 4 then monthly x 6. QA to ensure Dr. orders for b/p parameters are being followed and only

	medications that are crushable per the FDA will be crushed outcome will be discussed during QA meetings and medication aides will be having ongoing educational inservices. Pharmacist will follow and monitor medication aides passes when here on his scheduled visit C. QA checklist and monitoring daily x 2 weeks then weekly x 4 then monthly x 6 Monitoring auditing and using check off list.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/22/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Rachel Ray ED** Rachel Ray ED. OAC 310:663-25-4(F)	**Date 8/4/2023**

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: RachelR@knownmemorycare.com

October 11, 2023

License Number: AL7238

Ms. Rachel Ray, Administrator
Known Memory Care
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event P6Z212

Dear Ms. Ray:

On **October 10, 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 **June 21, 2023,** have now been corrected effective **September 22, 2023.**

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

Respectfully,

Lisa Calvin

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

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
	AL7238	A. BUILDING: _____ B. WING _____	R 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOWN MEMORY CARE	7807 S MINGO RD TULSA, OK 74133

(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 10/10/2023. 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