OKLAHOMA
State Department
of Health

**Delivery via email to:** RachelR@knownmemorycare.com

October 20, 2023

License Number: AL7238

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

**Survey Event ID: KJRD11**

Dear Ms. Ray:

On **October 11, 2023,** 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 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 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 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.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility: Known Memory Care**
**Address:** **7807 S Mingo RD**
**City, State, Zip:** **Tulsa, OK 74133**
**Provider #:** **AL7238**
**Complaint #:** **OK00055709**
**Investigation Dates:** **10/10/23 and 10/11/23**

## ALLEGATION

The center failed to provide adequate medical care and services.

An unannounced on-site investigation was initiated 10/10/2023 at 11:22 a.m.

A sample of three 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 Centers for Medicare and Medicaid Services (CMS) 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. Resident hallways were observed for staff assistance with resident care needs, the presence of odors and call lights. Equipment was observed for functionality.

Grievance reports and Resident Council minutes, incident reports, menus, policies and procedures were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, treatment records, and Activities of Daily Living (ADL) sheets were reviewed.

Family members, staff and residents were interviewed regarding if they felt their care needs were being met. Staff members were interviewed regarding the facility's policy on abuse and neglect.

The attached CMS 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: 10/12/2023

10/12/2023

# INVESTIGATIVE REPORT

**Facility: Known Memory Care**
**Address:** **7807 S Mingo RD**
**City, State, Zip:** **Tulsa, OK 74133**
**Provider #:** **AL7238**
**Complaint #:** **OK00061211**
**Investigation Dates:** **10/10/23 and 10/11/23**

## ALLEGATIONS

| |
|---|
| The facility failed to ensure medications were administered according to the physicians' orders and failed to ensure adequate hydration was received |
| The facility failed to ensure activities were provide according to the plan of care. |
| The facility failed to ensure residents/representatives were notified of changes, residents were treated with dignity and respect and services were billed according to the contract and in a timely manner |
| The facility failed to ensure eating utensils and drinks were provided according to preferences/needs. |
| The facility failed to ensure adequate, safe lighting was provided. |
| The facility failed to ensure adequate staff to meet the needs of the residents. |

An unannounced on-site investigation was initiated 10/10/2023 at 11:22 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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. Resident hallways were observed for staff assistance with resident care needs, the presence of odors and call lights. Activities were observed. Meals were observed at various times throughout the survey.

Grievance reports and Resident Council minutes, incident reports, menus, policies and procedures were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, treatment records, and Activities of Daily Living (ADL) sheets were reviewed.

Family members, staff and residents were interviewed regarding if they felt their care needs were met, notifications, and treatment of residents. Staff members were interviewed regarding the facility's policies.

The attached CMS 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: 10/12/2023

# INVESTIGATIVE REPORT

**Facility: Known Memory Care**
**Address:** **7807 S Mingo RD**
**City, State, Zip:** **Tulsa, OK 74133**
**Provider #:** **AL7238**
**Complaint #:** **OK00061269**
**Investigation Dates:** **10/10/23 and 10/11/23**

## ALLEGATIONS

| |
|---|
| The center failed to ensure residents were not physically, verbally, psychosocially abused or involuntarily isolated. |
| The center failed to ensure residents were being assisted with meals and were being provided adequate nutrition and hydration. |
| The center failed to ensure qualified staff were providing care for dependent residents |

An unannounced on-site investigation was initiated 10/10/2023 at 11:22 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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. Resident hallways were observed for staff assistance with resident care needs, the presence of odors, access to fluids, and call lights. Activities were observed. Meals were observed at various times throughout the survey.

Grievance reports and Resident Council minutes, incident reports, menus, policies and procedures were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, treatment records, and Activities of Daily Living (ADL) sheets were reviewed.

Family members, staff and residents were interviewed regarding care needs, notifications, and treatment of residents. Staff members were interviewed regarding the facility's policies.

The attached CMS 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: 10/12/2023

10/12/2023

# INVESTIGATIVE REPORT

**Facility: Known Memory Care**
**Address:** **7807 S Mingo RD**
**City, State, Zip:** **Tulsa, OK 74133**
**Provider #:** **AL7238**
**Complaint #:** **OK00061382**
**Investigation Dates:** **10/10/23 and 10/11/23**

## ALLEGATIONS

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|---|---|
| The center failed to ensure food was properly stored, dated, rotated and discarded. | |
| The center failed to ensure staff followed kitchen/dietary policies and procedures, to include failure to use/follow menus, no temperature checks of prepared food, poor food handling techniques, poor hand washing, failure to provide balanced, nutritious meals and ensure snack times did not exceed the 14 hour window. | |
| The center failed to have qualified kitchen staff, including a dietary manager, staff with up-to-date food handlers certificates, no dietician on staff. The center failed to ensure the Administrator and DON were properly licensed. | |
| The center failed to ensure adequate staff to provide care for dependent residents. | |

An unannounced on-site investigation was initiated 10/10/2023 at 11:22 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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. Resident hallways were observed for staff assistance with resident care needs, the presence of odors, access to fluids, and call lights. Activities were observed. Meals were observed at various times throughout the survey.

Grievance reports and Resident Council minutes, incident reports, menus, policies and procedures were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, treatment records, and Activities of Daily Living (ADL) sheets were reviewed.

A visual count of direct care nursing staff on duty was taken and compared to the State mandated staffing requirement. Past facility staffing schedules were reviewed for staffing patterns and compared to the State mandated staffing requirements. Grievance reports were reviewed. Staff training records and licenses related to job requirements were reviewed

Family members, staff and residents were interviewed regarding care needs, notifications, and treatment of residents. Staff members were interviewed regarding the facility's policies.

The attached CMS 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: 10/12/2023

# INVESTIGATIVE REPORT

**Facility: Known Memory Care**
**Address:** **7807 S Mingo RD**
**City, State, Zip:** **Tulsa, OK 74133**
**Provider #:** **AL7238**
**Complaint #:** **OK00061555**
**Investigation Dates:** **10/10/23 and 10/11/23**

## ALLEGATION

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

An unannounced on-site investigation was initiated 10/10/2023 at 11:22 a.m.

A sample of three 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 Centers for Medicare and Medicaid Services (CMS) 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. Resident hallways were observed for staff assistance with resident care needs, the presence of odors and call lights. Equipment was observed for functionality.

Grievance reports and Resident Council minutes, incident reports, menus, policies and procedures were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, treatment records, and Activities of Daily Living (ADL) sheets were reviewed.

Family members, staff and residents were interviewed regarding if they felt their care needs were being met. Staff members were interviewed regarding the facility's policy on abuse and neglect.

The attached CMS 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: 10/12/2023

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 _____ | C 10/11/2023 |

| 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<br><br>Complaint investigations (#OK00061555, #OK00061382, #OK00061269, #OK00061211, and #OK00055709) were conducted on 10/10/23 and 10/11/23. | C 000 | | |
| C1952 SS=D | 310:663-19-3(b) MAINTENANCE OF RECORDS<br><br>(b) Each resident's records shall be retained for at least five (5) years after the resident's transfer, discharge or death. Destruction of records shall be done in a manner to preserve resident confidentiality.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the center failed to ensure resident records were maintained and available for five years after the resident's transfer, discharge, or death for one (#4) of two discharged or deceased residents.<br><br>Findings:<br><br>On 10/11/23 at 3:30 p.m., the executive director was asked to submit closed records for one resident (#4) who had transferred, expired, or discharged.<br><br>On 10/11/23 at 3:55 p.m., the executive director stated they were unable to locate the records for Resident #4.<br>They were asked the center's policy for maintaining resident records. They stated, "I think the law is five years". | C1952 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** RachelR@knownmemorycare.com

November 17, 2023

License Number: AL7238

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

**Survey Event ID: KJRD11**

Dear Ms. Ray:

On **October 11, 2023,** 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 have been corrected and you were in substantial compliance by **November 7, 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

Enclosure

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 10/30/2023**<br>**Facility Name:** Known Memory Care<br>**License Number:** AL7238<br>**Survey Event ID:** KJRD11<br>**Date Survey Completed: 10/11/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C1952, SS=D | Based on: Record review and interview the center failed to ensure resident records were maintained and available for five years after the residents transfer, discharge or death for one (#4) of two discharged or deceased residents. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Maintenance records will be maintained for current maintenance records at community for current residents that have transferred , discharged or deacesed for 5 years. Destruction after 5 years will be done in a manner to preserve residents confidentiality.

| **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? | Admistrator and Business office Director since hire date of 7-21-2023 have ensured that all transfers, discharged or deceased maientance records have been maintained and will continue to ensure that all transfers, discharges and deceased maintenance records are kept for 5 years and Destruction will be done in a manner after 5 years to preserve residents confidentiality |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | Administrator and Businss office Director and Resident service director will continue to ensure that maintenance records for transfers, discharged or deceased records will be filed and kept stored in safe available space to ensure that records are safe and available at all times. Maintenance records will be only destroyed after 5 years and will be done to preserve residents confidentiality. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? | Resident Service Director will complete a Check off list monitoring each transfer, discharge or deceased resident, to ensure that all residents Transfering, discharging or deceased maintenance records will be broke down and filed in safe and available spot to ensure that the maintenance records are safe and easily available to obtain for 5 years. After 5 years destruction of maintenance records will be done in a manner to preserve confidentiality |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and | a. Resident Service Director will use check off list and monitor x 3 months resident's that have transferd, discharged or have deceased to ensure that all residents charts are broke down and stored safely for 5 years. No maintenance records will be destroyed before 5 years. Administrator will monitor to ensure check of list is being completed along with maintenance records being properly |

| | |
|---|---|
| c. How monitoring records will be kept to evidence the correction. | filed after each discharge , transfer or death of a resident.<br><br>b. Storeing of maintenance records for all transfers, dishcharges and deceased residents for 5 years and not destroyed before 5 years and after 5 years destruction of maintenance records will be destroyed in a manner to preserve confidentiality, POC will be addressed in next QA meeting along with check list and monitoring put in place.<br><br>c.Administrator will monitor check off list and stored maintenance records completed by Resident Service Director or designee after each transfer, discharge or death x 3 months to ensure that all charts are being broken down and maintenance records are being stored safely and records are readily available when needed after each transfer, discharge to ensure that records are kept x 5 years.<br><br>Checkoff list to monitor charts being broken down and maintenance records stored safely to be completed by Resident Service Director, LPN and over seen by Administrator to ensure charts broken down and stored saftely after each tranfer, discharge or deceased x 3 months. Administor after 3 months will continue to ensure that maintenance records are strored safely and available. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 11/7/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| **Administrator's Signature** **Rachel Ray LPN, ED** OAC 310:663-25-4(F) Rachel Ray ED. | **Date 10/30/2023** |
| 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.<br>Facility in Compliance by: Click here to enter a date. | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** RachelR@knownmemorycare.com

December 18, 2023

License Number: AL7238

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

**Survey Event ID: KJRD12**

Dear Ms. Ray:

On **December 15, 2023,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 11, 2023,** have now been corrected effective **November 7, 2023.**

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
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 |
|---|---|---|---|
| | AL7238 | A. BUILDING: _____ B. WING _____ | R-C 12/15/2023 |

| 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<br><br>An offsite/paper revisit was conducted on 12/15/23. The facility was in substantial compliance. | {C 000} | | |

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