OKLAHOMA
State Department
of Health

Delivery via email to: edna-lees1986@yahoo.com

July 15, 2021

License Number: RC1806
Survey Event ID: EBXO11

Ms. Edna Keaton, Administrator
Edna Lee's Residential Care
421 West South Avenue
Vinita, OK 74301

Dear Ms. Keaton:

Enclosed is the summary of deficiencies from the complaint investigation conducted at your Residential Care facility on **June 30, 2021**.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the spaces provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

- A statement of exactly how the facility has or intends to correct each deficiency.
- The method of correction. This includes who is responsible for the correction.
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- A reasonable date of correction, which will normally be within 30 days of this notice.

  NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **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 this completed form for your files.

In the event that we find your Plan of Correction unacceptable, you will be notified of the reason(s) it is not acceptable and we will request another Plan of Correction. If your plan of correction is acceptable, there will be no acknowledgement. We will conduct a revisit in accordance with your stated correction dates. If you have any questions concerning this letter, please contact me at (405) 426-8200.

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You will be notified you of any enforcement actions being taken. If you have questions or need assistance, please feel free to contact me at (405) 426-8200.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.07.15 13:57:31 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Edna Lees Residential Care**
Address: **421 West South Avenue**
City, State, Zip: **Vinita, Oklahoma 74301**
Provider #: **RC1806**
Complaint #: **#OK00057302**
Investigation Date(s): **06/28/2021 to 06/30/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to adequately train staff or implement an effective policy for providing emergency medical services.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 06/28/2021 at 8:17 a.m.

A sample of 3 residents including any identified resident(s), 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, R813 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #OK00057302. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Mary Cooper By Ed Rich

Mary Cooper RN/CHFS

Date report completed: 06/30/2021

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	RC1806	A. BUILDING: _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDNA LEE'S RESIDENTIAL CARE	421 WEST SOUTH AVENUE VINITA, OK 74301

(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
R 000	INITIAL COMMENTS An abbreviated survey was conducted on 06/28/2021 through 06/30/2021 to investigate complaint #OK00057302. Deficient practice was cited. Census was 55.	R 000		
R 631 SS=D	310:680-13-1 (2)(C) ADMINISTRATION OF MEDICATIONS (2) Administration of Medications. (C) The person administering the medication shall maintain an accurate written record of medications administered. This Rule is not met as evidenced by: Based on interview and record review it was determined the home failed to ensure an accurate record of medications was documented for one (#1) of three sampled residents for accurate medication administration records (MAR). This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #1 was admitted to the home on 06/24/2020 with diagnoses which included, Depression, Hyperlipidemia and Schizophrenia.	R 631		

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R 631	Continued From page 1 On 06/30/2021 at 08:19 a.m., resident #1's MAR was reviewed with the administrator. She was asked why the MAR dated 06/23/2021 documented that the Mirtazapine Trihexyphen and Olanzapine were administered to the resident by Employee #1 (Medication Administration Technician) at 9:00 p.m. when the resident was no longer in the facility. She stated, "I don't know, we pulled his meds when he passed that morning." She was also asked why there was no documentation that he had received his Atorvastatin 20 milligram at bedtime and Donepezil at bedtime at 9:00 p.m. on 06/21/2021 and 06/22/2021. She stated, " I don't know if she gave them, she didn't circle if he refused."	R 631		
R 813 SS=K	310:680-19-2 (a)(5) STATEMENT PROVISIONS (a) A statement of rights and responsibilities shall include but not be limited to the following: (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 shall be fully informed by his attending physician of his medical condition and proposed treatment in terms and language that the resident can understand, unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions.	R 813		

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R 813	Continued From page 2	R 813		

This Rule is not met as evidenced by:
On 06/28/21 at 1:20 p.m., the Oklahoma State Department of Health (OSDH) confirmed the existence of an immediate jeopardy related to staff not performing Cardiopulmonary Resuscitation (CPR) on a resident who was found unresponsive. The facility had no system and/or policy or procedure to identify residents code status. On 06/23/21, resident #1 was found unresponsive in a chair in the television room. Three staff responded to the incident, but did not start CPR.

At 1:26 p.m., the administrator was informed of the existence of the immediate jeopardy. A request was made for an acceptable plan to remove the immediacy.

On 06/28/2021 at 5:10 p.m., the home submitted an acceptable plan of removal, the plan of removal was as follows:

"Edna Lee's Residential Care Plan of Removal on 06/28/2021"

"I have written a policy on what to do if a resident is found unresponsive, and I will call in my staff and have a staff meeting at 6:00 p.m., on 06/28/2021. I am having a resident meeting at 2:10 p.m. on 06/28/20201 to see which residents want to sign a DNR, and which residents do not. If they would like to sign a DNR they can come by my office and sign one by 09:30 am on 06/29/2021. If a resident has a guardian, I will

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R 813	Continued From page 3	R 813		

notify the guardian by 4:45 p.m. on 06/28/2021 that they need to fill out a DNR for that resident if they want them to have one. I will put a heart by the residents' names on their cubbies for the residents that want to be resuscitated. This will be completed by 9:00 am on 06/29/2021. Administrator will be responsible to make sure the heart is put by the resident's name. Will in-service staff by 08:30 am on 06/29/2021 on final plan of removal. If there is no heart by a residents name that means they have a DNR. I will add a DNR to the residents' admission packet that they can fill out at the time of admission if they want this will be completed by 1:00 p.m. on 06/28/2021.
On 06/29/2021 at 11:15 a.m., after interviews with staff members it was determined the in-service for 08:30 am was not completed with all staff members. The administrator was asked to submit an amended plan of removal to complete this training.

On 06/29/2021 at 12:00 p.m., the home submitted an amended plan of removal, due to not completing the in-service on 06/29/2021 at 08:30 am.

"Plan of removal amendment on 06/29/2021 at 11:50 am"

Will have my staff full in-serviced by 8:00 am on 06/30/2021. In-service will be over hearts on all the cubbies, the hearts mean that a resident does not have a DNR so you will perform CPR on that resident, and where to find the mouth guard for CPR, that we do not have no DNR'S at this time, but that can always change at any time.

A review of the facilities in-service, staff interviews, resident interviews and observations

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R 813	Continued From page 4 of the resident cubbies were completed. The plan of removal was completed and the immediacy was removed on 06/30/2021 at 9:11 a.m. This deficiency remained at a level two at a pattern. Based on observation, interview and record review, it was determined the home failed to: ~ perform CPR to an unresponsive resident with no pulse; ~ have a policy and procedure for staff on how to respond to a resident who is unresponsive; and ~ have a system in place for staff to identify which residents were a DNR or wanted CPR. The home identified 55 residents that have no advanced directives. Findings: Resident #1 was admitted to the home on 06/24/20 with diagnoses which included, Depression, Hyperlipidemia, and Schizophrenia. Resident #1's "Emergency Information Form" kept in the medication administration record documented, " ...Advanced Directive? Y or N ..." Nothing was marked to identify if resident #1 had any Advanced Directives. A facility form in resident #1's admission packet titled "Residential Care Home Residents Bill of Rights" dated 01/01/21, documented " ...Right 2: To receive care and services which are adequate, appropriate and in compliance ..."	R 813		

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R 813	Continued From page 5 A facility form in resident #1's admission packet titled, "Edna Lee's Residential Care, Inc." dated 06/25/20 documented, " ... Legal Status was marked competent ..." On 06/28/2021 at 9:30 a.m., employee #2 was asked what happened the day resident #1 was found unresponsive. She stated, "He got his meds, next thing we knew the residents came running up from the TV room hollering, we can't wake resident #1 up." Three staff ran to the tv room. Employee #1 checked for a pulse and checked if he was breathing, employee #3 called 911, then the administrator." Employee #2 was asked if anyone started CPR. She stated, "No, employee #1 said he is already passed." Employee #2 was asked if she knew if resident #1 was a full code. She replied, I couldn't tell you. At 9:40 a.m., employee #1 was asked what happened the day resident #1 was found unresponsive. She stated, "employee #3 and I ran down the hall, to the resident and he had no color or pulse. The employee stated the resident's head was flopped over in the chair, and employee #3 called 911. The employee added they had checked for respirations, grabbed a rubber glove, checked his hand, and he had no pulse." She was asked, how you knew what his code status was, she replied, in that situation I don't know if he wanted it or not. At 9:55 a.m., employee #3 was asked what happened the day client #1 was found unresponsive. She replied, he missed breakfast so we went walking around. A resident came running up and said "resident #1 won't wake up." She was asked if any staff started CPR, she	R 813		

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R 813	Continued From page 6	R 813		

stated "He had no pulse". She was asked where the client wishes were documented. She stated, "I have never seen any document of what they want." She was asked, if anyone started CPR? She replied, none of us did.

At 11:20 a.m., the administrator was asked if the home had a policy and procedure for emergency situations, including CPR. She stated "No." She was unsure why staff had not started CPR, and stated, "I would have performed CPR." She reported none of the residents have any advanced directives on file. She was asked how staff know what the residents' code status was, she stated "they don't."

A facility form titled "Confidential Critical Incident Report" completed by employee #1 and #3 documented:

Employee #1: Dated 06/23/2021 at 07:40 a.m., " ...I went into the room and checked ... I saw that he had a pale pallor and I saw no respirations or felt no breath. I put on gloves and checked for a pulse and found none. He was also cool to the touch ..."

Employee #2: Dated 06/23/2021 at 07:40 a.m., "... at 7:00 a.m. started passing meds passed resident #1's meds and he went to the tv room to wait on breakfast and at approximately 7:40 a.m. employee #2 was yelling for me and employee #1 to come to the tv room where resident #1 was sitting and employee #1 told me to call 911..."

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Delivery via email to: edna_lees1986@yahoo.com

July 29, 2021

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Ms. Edna Keaton, Administrator
Edna Lee's Residential Care
421 West South Avenue
Vinita, OK 74301

Dear Ms. Keaton:

On **June 30, 2021**, a complaint investigation was conducted at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 13, 2021**.

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.

Sincerely,

Tempal Killman Digitally signed by Tempal Killman
Date: 2021.07.29 11:05:24 -05'00'

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

enc

Oklahoma State Department of Health

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R 000	INITIAL COMMENTS An abbreviated survey was conducted on 06/28/2021 through 06/30/2021 to investigate complaint #OK00057302. Deficient practice was cited. Census was 55.	R 000		
R 631 SS=D	310:680-13-1 (2)(C) ADMINISTRATION OF MEDICATIONS (2) Administration of Medications. (C) The person administering the medication shall maintain an accurate written record of medications administered. This Rule is not met as evidenced by: Based on interview and record review it was determined the home failed to ensure an accurate record of medications was documented for one (#1) of three sampled residents for accurate medication administration records (MAR). This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #1 was admitted to the home on 06/24/2020 with diagnoses which included, Depression, Hyperlipidemia and Schizophrenia.	R 631	On 7/12/21 I had a staff meeting with my employees and went over the importance of documenting on the MARS and paying attention to what you are doing while documenting. I made a copy of residents #1 MARS to use as an example of the medication errors. The employee that did these medication errors was terminated on 7/13/2021.	7/13/2021

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place, or if the wanted to get a DNR.

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R 813	Continued From page 3	R 813		
	notify the guardian by 4:45 p.m. on 06/28/2021 that they need to fill out a DNR for that resident if they want them to have one. I will put a heart by the residents' names on their cubbies for the residents that want to be resuscitated. This will be completed by 9:00 am on 06/29/2021. Administrator will be responsible to make sure the heart is put by the resident's name. Will in-service staff by 08:30 am on 06/29/2021 on final plan of removal. If there is no heart by a residents name that means they have a DNR. I will add a DNR to the residents' admission packet that they can fill out at the time of admission if they want this will be completed by 1:00 p.m. on 06/28/2021. On 06/29/2021 at 11:15 a.m., after interviews with staff members it was determined the in-service for 08:30 am was not completed with all staff members. The administrator was asked to submit an amended plan of removal to complete this training. On 06/29/2021 at 12:00 p.m., the home submitted an amended plan of removal, due to not completing the in-service on 06/29/2021 at 08:30 am. "Plan of removal amendment on 06/29/2021 at 11:50 am" Will have my staff full in-serviced by 8:00 am on 06/30/2021. In-service will be over hearts on all the cubbies, the hearts mean that a resident does not have a DNR so you will perform CPR on that resident, and where to find the mouth guard for CPR, that we do not have no DNR'S at this time, but that can always change at any time. A review of the facilities in-service, staff interviews, resident interviews and observations		6/29/21 I submitted an amended plan of removal stating I would have my staff fully in-serviced by 8:00am on 6/30/21.This in-service would be hearts on cubbies next to resident's name means that resident will get CPR. Residents with no hearts have a DNR. It will be the administrator's responsibility to make sure the hearts are placed next to residents name on cubbies. Where to find the mouth guard for CPR.	6/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC1806	A. BUILDING: _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDNA LEE'S RESIDENTIAL CARE	421 WEST SOUTH AVENUE VINITA, OK 74301

(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

R 813	Continued From page 4 of the resident cubbies were completed. The plan of removal was completed and the immediacy was removed on 06/30/2021 at 9:11 a.m. This deficiency remained at a level two at a pattern. Based on observation, interview and record review, it was determined the home failed to: ~ perform CPR to an unresponsive resident with no pulse; ~ have a policy and procedure for staff on how to respond to a resident who is unresponsive; and ~ have a system in place for staff to identify which residents were a DNR or wanted CPR. The home identified 55 residents that have no advanced directives. Findings: Resident #1 was admitted to the home on 06/24/20 with diagnoses which included, Depression, Hyperlipidemia, and Schizophrenia. Resident #1's "Emergency Information Form" kept in the medication administration record documented, " ...Advanced Directive? Y or N ..." Nothing was marked to identify if resident #1 had any Advanced Directives. A facility form in resident #1's admission packet titled "Residential Care Home Residents Bill of Rights" dated 01/01/21, documented " ...Right 2: To receive care and services which are adequate, appropriate and in compliance ..."	R 813	On 7/12/21 I did in-service with staff on new first aide kits, and where the first aide kits are kept, and were to find CPR mouth guards in the first aide kit. I also bought CPR mouth guards to go on all facility key chains that staff use. On 7/26/2021 All staff will be doing a training with the RN for our facility on charting in the MARS, and the importance of doing CPR, and when to do it and when not to do CPR.	7/12/2021 7/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC1806	A. BUILDING: _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDNA LEE'S RESIDENTIAL CARE	421 WEST SOUTH AVENUE VINITA, OK 74301

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R 813	Continued From page 5 A facility form in resident #1's admission packet titled, "Edna Lee's Residential Care, Inc." dated 06/25/20 documented, " ... Legal Status was marked competent ..." On 06/28/2021 at 9:30 a.m., employee #2 was asked what happened the day resident #1 was found unresponsive. She stated, "He got his meds, next thing we knew the residents came running up from the TV room hollering, we can't wake resident #1 up." Three staff ran to the tv room. Employee #1 checked for a pulse and checked if he was breathing, employee #3 called 911, then the administrator." Employee #2 was asked if anyone started CPR. She stated, "No, employee #1 said he is already passed." Employee #2 was asked if she knew if resident #1 was a full code. She replied, I couldn't tell you. At 9:40 a.m., employee #1 was asked what happened the day resident #1 was found unresponsive. She stated, "employee #3 and I ran down the hall, to the resident and he had no color or pulse. The employee stated the resident's head was flopped over in the chair, and employee #3 called 911. The employee added they had checked for respirations, grabbed a rubber glove, checked his hand, and he had no pulse." She was asked, how you knew what his code status was, she replied, in that situation I don't know if he wanted it or not. At 9:55 a.m., employee #3 was asked what happened the day client #1 was found unresponsive. She replied, he missed breakfast so we went walking around. A resident came running up and said "resident #1 won't wake up." She was asked if any staff started CPR, she	R 813	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC1806	A. BUILDING: _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDNA LEE'S RESIDENTIAL CARE	421 WEST SOUTH AVENUE VINITA, OK 74301

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R 813	Continued From page 6 stated "He had no pulse". She was asked where the client wishes were documented. She stated, "I have never seen any document of what they want." She was asked, if anyone started CPR? She replied, none of us did. At 11:20 a.m., the administrator was asked if the home had a policy and procedure for emergency situations, including CPR. She stated "No." She was unsure why staff had not started CPR, and stated, "I would have performed CPR." She reported none of the residents have any advanced directives on file. She was asked how staff know what the residents' code status was, she stated "they don't." A facility form titled "Confidential Critical Incident Report" completed by employee #1 and #3 documented: Employee #1: Dated 06/23/2021 at 07:40 a.m., " ...I went into the room and checked ... I saw that he had a pale pallor and I saw no respirations or felt no breath. I put on gloves and checked for a pulse and found none. He was also cool to the touch ..." Employee #2: Dated 06/23/2021 at 07:40 a.m., "... at 7:00 a.m. started passing meds passed resident #1's meds and he went to the tv room to wait on breakfast and at approximately 7:40 a.m. employee #2 was yelling for me and employee #1 to come to the tv room where resident #1 was sitting and employee #1 told me to call 911..."	R 813			

OKLAHOMA
State Department
of Health

Delivery via email to: edna_lees1986@yahoo.com

July 29, 2022

License Number: RC1806

Ms. Edna Keaton, Administrator
Edna Lee's Residential Care
421 West South Avenue
Vinita, OK 74301

Survey Event ID: EBXO12

Dear Ms. Keaton:

Enclosed is the summary of deficiencies following the revisit conducted at your Residential Care facility on **July 25, 2022**. The findings of the revisit indicate the deficiencies cited during your survey **June 30, 2021**, have now been corrected effective **July 27, 2021**

You will be notified of any enforcement actions being taken. If you have questions or need assistance, please feel free to contact us at (405) 426-8200.

In accordance with O.S. 63 830.1, 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 833-RC). 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 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 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 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.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

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
	RC1806	A. BUILDING: _____ B. WING _____	R-C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDNA LEE'S RESIDENTIAL CARE	421 WEST SOUTH AVENUE VINITA, OK 74301

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{R 000}	INITIAL COMMENTS A revisit was conducted from 07/25/22. All deficiencies from the 06/30/21 survey were cleared.	{R 000}		

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