OKLAHOMA
State Department
of Health

Delivery via email to: jennifer@gladeavenueassistedliving.com

May 15, 2026

License Number: AL5511

Ms. Jennifer Beagle, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: YZH811

Dear Ms. Beagle:

On **May 6, 2026,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement, and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record, and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or a virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to: IDRCoordinator@health.ok.gov

Or **mail** to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Tempal Killman

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Glade Avenue North
Address: 2500 North Glade Ave
City, State, Zip: Bethany, OK 73008
Provider #: AL5511
Complaint #: OK00089772
Investigation Date(s): 05/06/26

ALLEGATION(S)
The facility failed to ensure residents were billed according to their contract
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 05/06/2026 at 8:20 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation: Records of residents' contracts, billing statements, accounting ledgers, residents' assessments, and care plans were reviewed. Interviews with residents, families, and staff were conducted. Based on record review and interview, the center was not in compliance with regulations.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 05/06/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Glade Avenue North
Address: 2500 North Glade Ave
City, State, Zip: Bethany, OK 73008
Provider #: AL5511
Complaint #: OK00089779
Investigation Date(s): 05/06/26

ALLEGATION(S)
The facility failed to ensure residents were free from abuse
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 05/06/2026 at 8:20 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation: Observations of residents' physical and behavioral condition, resident to resident and staff to resident interactions, and visitor to resident interactions were made. Records of residents' assessments, care plans, physician notes, nurse's notes, powers of attorney documents, billing statements, accounting ledgers, and resident health records were reviewed. Interviews with residents, families, and staff were conducted.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 05/06/2026

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
	AL5511	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

(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 Complaint investigations (#OK00089772 and #OK00089779) were conducted on 05/06/26. Deficiencies were cited. Facility Census: 66	C 000		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure common areas were clean and/or in good repair for 3 (#200, 300, and #400) of 4 halls observed. The administrator identifed 66 residents resided in the facility. Findings: On 05/06/26 at 8:23 a.m., the main hall flooring had white splatters of paint and holes in the laminate. On 05/06/26 at 8:24 a.m., hall 300's carpet was observed with a ripped seam and fraying edges in front of apartment 301. A large beige stain approximately 2 feet in width and 1 foot in length was on the carpet in front of apartment 304. There was a large, ripped seam in the middle of hall 300 running the length of the hallway. There were several small, scattered black stains throughout the entire hallway carpet.	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5511	A. BUILDING: _____ B. WING _____	C 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

(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
C1304	Continued From page 1 On 05/06/26 at 8:30 a.m., it was observed that the dining room laminate floor had white splatters of what appeared to be paint and holes in the laminate. On 05/06/26 at 8:35 a.m., it was observed that hall 400's carpet had a black stain down the middle of the hallway running approximately 4 foot long and 6 inches wide. There were multiple large black stains in front of apartment 416 and throughout the rest of hall 400. There was an area approximately 1 foot 6 inches long of a ripped seam with frayed edges against the wall near apartment 405. On 05/06/26 at 9:00 a.m., hall 200's carpet was observed with multiple large and small black stains throughout the entire hall. On 05/06/26 at 8:37 a.m., the maintenance supervisor stated the new flooring was supposed to have been delivered for installation the week of 04/27/26. They stated the new flooring was not the right color and had to be reordered. The maintenance supervisor did not have a timeframe of when the new flooring would be delivered after the reorder. On 05/06/26 at 11:36 a.m., the administrator stated they were not aware of an updated timeframe for delivery of the new flooring for the center. On 05/06/26 at 11:43 a.m., the maintenance supervisor stated they were only occasionally spot cleaning the carpets in the building because the carpet was so thin they could not get it too wet.	C1304		

OKLAHOMA
State Department
of Health

Delivery via email to: jennifer@gladeavenueassistedliving.com

June 4, 2026

License Number: AL5511

Ms. Jennifer Beagle, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: YZH811

Dear Ms. Beagle:

On **May 6, 2026**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- The Plan of Correction does not address the replacement of flooring in halls 200 and 300. The maintenance man had stated they have to be replaced; they cannot clean them.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/29/2026** **Facility Name:** Glade Avenue Assisted Living **License Number:** AL5511 **Survey Event ID:** YZH811 **Date Survey Completed: 5/6/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on: observation, record review, and interview, the facility failed to ensure common areas were clean and/or in good repair for 3 (#200, 300, and #400) of 4 halls observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted as the facility's credible allegation of compliance. Preparation and submission of this Plan of Correction does not constitute agreement with the deficiency cited and is submitted solely to comply with regulatory requirements.

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 facility immediately conducted a review of all common areas identified during the survey. Carpeted areas with visible stains were cleaned where feasible. Damaged carpet seams were secured to prevent further fraying and reduce potential trip hazards pending replacement. Areas of damaged laminate flooring in the main hallway and dining room were assessed and scheduled for replacement. Residents continued to have unrestricted access to safe common areas while corrective measures were implemented. Hall 400 flooring was started 5/27/26
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The ED, Maint. Director, or other designee will complete a comprehensive inspection of all resident hallways, common areas, dining areas, and other shared spaces throughout the building to identify any additional flooring damage, carpet wear, stains, frayed seams, or maintenance concerns requiring correction. Any identified issues will be added to the facility maintenance tracking system for resolution.
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 facility has implemented a routine environmental inspection process. Maintenance personnel will conduct monthly documented inspections of all resident hallways, common areas, and flooring surfaces to identify concerns requiring repair or replacement. A preventive maintenance log has been implemented to track flooring conditions, carpet condition, repair needs, vendor orders, and completion dates. Housekeeping and maintenance staff have been educated regarding prompt reporting of damaged flooring, excessive carpet wear, stains, or other environmental concerns to facility leadership for timely follow-up.
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.	Methods to Ensure Corrections are Sustained:Monthly environmental rounds will be conducted by the Administrator or designee and Maintenance Supervisor to verify common areas remain clean and in good repair. Methods to Evaluate Effectiveness:Results of monthly inspections will be reviewed to ensure identified concerns are corrected timely. Any recurring concerns will be evaluated for root cause and additional corrective action. Methods to Incorporate into QA System:Findings from environmental rounds and maintenance audits will be reviewed during the facility Quality Assurance/Performance Improvement process for ongoing oversight. Methods to Keep Monitoring Records:Inspection forms, maintenance logs, repair work orders, vendor invoices, flooring replacement documentation, and Quality Assurance meeting records will be maintained by the facility and available for review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/7/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Jennifer Beagle, Executive Director OAC 310:663-25-4(F)	**Date 5/29/2026**

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: jennifer@gladeavenueassistedliving.com

June 30, 2026

License Number: AL5511

Ms. Jennifer Beagle, Executive Director
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: YZH811

Dear Ms. Beagle:

On **May 6, 2026,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by July 7, 2026.

We will conduct a revisit to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/29/2026** **Facility Name:** Glade Avenue Assisted Living **License Number:** AL5511 **Survey Event ID:** YZH811 **Date Survey Completed: 5/6/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on: observation, record review, and interview, the facility failed to ensure common areas were clean and/or in good repair for 3 (#200, 300, and #400) of 4 halls observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted as the facility's credible allegation of compliance. Preparation and submission of this Plan of Correction does not constitute agreement with the deficiency cited and is submitted solely to comply with regulatory requirements.

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 facility immediately conducted a review of all common areas identified during the survey. Carpeted areas with visible stains were cleaned where feasible. Damaged carpet seams were secured to prevent further fraying and reduce potential trip hazards pending replacement. Areas of damaged laminate flooring in the main hallway and dining room were assessed and scheduled for replacement. Residents continued to have unrestricted access to safe common areas while corrective measures were implemented. Hall 400 flooring was started 5/27/26 and completed 5/31/26. Owner inspected flooring 6/9 and approved replacement of 200 & 300. Wyatt Jones with Brim's Carpet emailed 6/16/26 to confirm material was ordered for 200 & 300. Expected delivery by 6/23/26. Number of installers will be increased. Hall 300 install will be first with expected completion date 6/26/26. Hall 200 install second with expected completion date 6/30/26. If an unanticipated delay occurs, hall 200 & 300 flooring should be complete by 7/7/26. wyatt@brimscarpetokc.com 405 362-7334
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The ED, Maint. Director, or other designee will complete a comprehensive inspection of all resident hallways, common areas, dining areas, and other shared spaces throughout the building to identify any additional flooring damage, carpet wear, stains, frayed seams, or maintenance concerns requiring correction. Any identified issues will be added to the facility maintenance tracking system for resolution
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 facility has implemented a routine environmental inspection process. Maintenance personnel will conduct monthly documented inspections of all resident hallways,

	common areas, and flooring surfaces to identify concerns requiring repair or replacement. A preventive maintenance log has been implemented to track flooring conditions, carpet condition, repair needs, vendor orders, and completion dates. Housekeeping and maintenance staff have been educated regarding prompt reporting of damaged flooring, excessive carpet wear, stains, or other environmental concerns to facility leadership for timely follow-up.
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.	Methods to Ensure Corrections are Sustained:Monthly environmental rounds will be conducted by the Administrator or designee and Maintenance Supervisor to verify common areas remain clean and in good repair. Methods to Evaluate Effectiveness:Results of monthly inspections will be reviewed to ensure identified concerns are corrected timely. Any recurring concerns will be evaluated for root cause and additional corrective action. Methods to Incorporate into QA System:Findings from environmental rounds and maintenance audits will be reviewed during the facility Quality Assurance/Performance Improvement process for ongoing oversight. Methods to Keep Monitoring Records:Inspection forms, maintenance logs, repair work orders, vendor invoices, flooring replacement documentation, and Quality Assurance meeting records will be maintained by the facility and available for review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/7/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Jennifer Beagle, Executive Director OAC 310:663-25-4(F)	**Date 5/29/2026**

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	6/19/2026	**Submitted by**	Jennifer Beagle

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: jennifer@gladeavenueassistedliving.com

July 14, 2026

License Number: AL5511

Ms. Jennifer Beagle, Executive Director
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

RE: Survey Event YZH812

Dear Ms. Beagle:

On **July 13, 2026,** an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 6, 2026,** have now been corrected effective **July 7, 2026.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst II
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
	AL5511	A. BUILDING: _____ B. WING _____	R-C 07/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

(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 07/13/26. All deficiencies from the 05/06/26 survey were cleared.	{C 000}		

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