April 12, 2019

License Number: NH3608AL

Mr. Will Otjen, Administrator
Via Christi Village Ponca City, Inc
1601 Academy Road
Ponca City, OK 74604

RE: Survey Event ID: UTWF11

Dear Mr. Otjen:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **April 3, 2019.** No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
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
	NH3608AL	A. BUILDING: _____ B. WING _____	04/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PONCA CITY, INC	1601 ACADEMY ROAD PONCA CITY, OK 74604

(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 re-licensure survey was conducted on 04/03/19. The resident census was 44. No deficient practice was cited.	C 000		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
NH3608AL	VIA CHRISTI VILLAGE PONCA CITY, INC

Type of Survey (select all that apply)

2				

A	Complaint Investigation	E	Initial Certification	I	Recertification
B	Dumping Investigation	F	Inspection of Care	J	Sanctions/Hearing
C	Federal Monitoring	G	Validation	K	State License
D	Follow-up Visit	H	Life Safety Code	L	CHOW
M	Other				

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 32388	04/03/2019	04/03/2019	0.25	0.00	4.00	0.00	3.00	0.50
2. 18273	04/03/2019	04/03/2019	0.25	0.00	4.00	0.00	3.00	0.75
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00   Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00   Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**