

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>370001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/08/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>HILLCREST MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1120 SOUTH UTICA AVENUE</b> <b>TULSA, OK 74104</b>		
(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) COMPLETION DATE	
A 000	<p><b>INITIAL COMMENTS</b></p> <p>The Oklahoma State Department of Health conducted an unannounced on site complaint survey (OK00059250) from 08/04/22 to 08/08/22.</p> <p>An entrance conference was conducted on 08/04/22 at 11:20 am with administration and staff.</p> <p>An informal exit conference was conducted on 08/08/22 at 3:00 pm with administration and staff.</p> <p>No deficiencies were cited as a result of the survey.</p>	A 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
CMS Dallas - Survey & Operations Group  
1301 Young Street, Room 106-900  
Dallas, Texas 75202



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May 4, 2023

Our Reference: CCN 370001, Complaint Intake #OK00059250

Xavier Villareal, CEO  
Hillcrest Medical Center  
1120 South Utica Avenue  
Tulsa, OK 74104

Dear Mr. Villareal:

We have reviewed the reports of the August 8, 2022, complaint survey conducted by the Oklahoma State Department of Health. The complaint alleged noncompliance with the requirements of 42 CFR 489.24, *Responsibilities of Medicare Participating Hospitals in Emergency Cases* and the related requirements of 42 CFR 489.20.

We have determined that your hospital meets the requirements of the foregoing regulations based on the review of facility documents, medical records and interviews with facility staff.

Consequently, no enforcement action will be taken against your hospital concerning the referenced complaint above.

If you have any questions, please contact Tiffany Curtis Baird at 214-767-4404 or through email at [tiffany.curtis@cms.hhs.gov](mailto:tiffany.curtis@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "MF", is written over a light blue circular background.

Marcus Foster  
Acting Manager, Acute & Continuing Care Branch

cc: OSDH

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>370078</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/29/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>OKLAHOMA STATE UNIVERSITY MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>744 WEST 9TH STREET TULSA, OK 74127</b>		
(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) COMPLETION DATE	
A 000	<p><b>INITIAL COMMENTS</b></p> <p>The Oklahoma State Department of Health conducted an unannounced on site complaint survey (OK00059249) from 07/27/22 to 07/29/22.</p> <p>An entrance conference was conducted on 07/27/22 with administration and staff.</p> <p>An informal exit conference was conducted on 07/29/22 with administration and staff.</p> <p>No deficiencies were cited as a result of the survey.</p>	A 000			

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

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
CMS Dallas - Survey & Operations Group  
1301 Young Street, Room 106-900  
Dallas, Texas 75202



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May 4, 2023

Our Reference: CCN 370078, Complaint Intake #OK00059249

Finny Mathew, CEO  
Oklahoma State University Medical Center  
744 West 9th Street  
Tulsa, OK 74127

Dear Mr. Mathew:

We have reviewed the reports of the July 29, 2022, complaint survey conducted by the Oklahoma State Department of Health. The complaint alleged noncompliance with the requirements of 42 CFR 489.24, *Responsibilities of Medicare Participating Hospitals in Emergency Cases* and the related requirements of 42 CFR 489.20.

We have determined that your hospital meets the requirements of the foregoing regulations based on the review of facility documents, medical records and interviews with facility staff.

Consequently, no enforcement action will be taken against your hospital concerning the referenced complaint above.

If you have any questions, please contact Tiffany Curtis Baird at 214-767-4404 or through email at [tiffany.curtis@cms.hhs.gov](mailto:tiffany.curtis@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink, appearing to be "MF" or similar initials, written over a white background.

Marcus Foster  
Acting Manager, Acute & Continuing Care Branch

cc: OSDH