Oklahoma State Department of Health
Creating a State of Health

November 27, 2019

License Number: AL3801

Ms. Patricia Holt, Administrator
Woodland Gardens Assisted Living
915 North Broadway
Hobart, OK 73651

RE: Survey Event ID: OPYK11

Dear Ms. Holt:

On October 17, 2019, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on October 17, 2019.

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 (attached). *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 and monitoring will be completed for each violation;
(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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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.

Sincerely,

Lisa Calvin

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3801	A. BUILDING _____ B WING _____	10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND GARDENS ASSISTED LIVING	915 NORTH BROADWAY HOBART, OK 73651

(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 10/15/19 through 10/17/19. Current census was 11. The following deficient practices were cited.	C 000		
C 711 SS=F	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on interview and record review, the center failed to ensure an annual fire marshal inspection was completed. This failed practice resulted in the widespread potential for more than minimal harm for all 11 residents. Findings: On 10/15/19 at 4:52 p.m., a fire marshal's inspection report, dated 05/30/18, was provided. There was no current fire marshal inspection report available. The administrator/registered nurse stated the maintenance director coordinated the annual fire marshal's inspection.	C 711		
C1923 SS=F	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3801	A BUILDING _____ B WING _____	10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND GARDENS ASSISTED LIVING	915 NORTH BROADWAY HOBART, OK 73651

(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
C1923	Continued From page 1 administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure: a) Identity and signature of certified medication employees who administered medications to 6 (#1 through #6) of 6 sampled residents were identified on a medication administration record (MAR); and b) Certified medication employees who administered as needed medications to 3 (#1, 2, and #6) of 4 sampled residents recorded the date, time, dose, medication, and administration method on the MAR as required. These deficient practices had the widespread potential for more than minimal harm for all 11 residents. Findings:	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3801	A BUILDING _____ B WING _____	10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND GARDENS ASSISTED LIVING	915 NORTH BROADWAY HOBART, OK 73651

(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
C1923	Continued From page 2 SIGNATURES On 10/16/19 at 2:42 p.m., a review of resident #1's chart documented 3 certified medication employees' signatures on the September 2019 MAR. The administrator/registered nurse (RN) identified 3 certified medication aides (CMA) and 2 medication administration technicians (MAT) who had administered medications to resident #1. At 2:44 p.m., a review of resident #2's chart documented only three certified medication employee' signatures on the September 2019 MAR. At 4:19 p.m., a review of resident #4's chart documented only one certified medication employees' signature on the September 2019 MAR. At 4:27 p.m., a review of resident #3's chart documented only three certified medication employees' signatures on the September 2019 MAR. On 10/17/19 at 12:04 p.m., a review of resident #5's chart documented the September 2019 MAR had not been signed by any of the medication employees. At 12:11 p.m., a review of resident #6's chart documented only three certified employees' signatures on the September 2019 MAR. The administrator/RN identified other employees who had administered medications and did not sign their names. She stated the medication employees' knew the MARs required their initials as well as their signatures. She further stated	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3801	A BUILDING _____ B WING _____	10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND GARDENS ASSISTED LIVING	915 NORTH BROADWAY HOBART, OK 73651

(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
C1923	Continued From page 3 she had not monitored the MARs for medication employees' signatures. AS NEEDED MEDICATIONS On 10/16/19 at 2:42 p.m., a review of resident #1's September 2019 MAR documented as needed medications were administered four times to her. The date, time, dose, medication, and administration method had not been documented two of those times. At 12:44 p.m., a review of resident #2's June 2019 MAR documented as needed medications were administered five times to her. The date, time, dose, medication, and administration method had not been documented one of those times. A March 2019 MAR documented as needed medications were administered 19 times to her. The date, time, dose, medication, and administration method had not been documented seven of those times. On 10/17/19 at 12:04 p.m., a review of resident #6's September 2019 MAR documented as needed medications were administered six times to her. The date, time, dose, medication, and administration method had not been documented four of those times. The administrator/RN stated the medication employees knew the date time, dose, medication, and administration method was supposed to be documented on the MAR at the time as needed medications were administered but she thought the employees had been in a hurry.	C1923		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL3801	WOODLAND GARDENS ASSISTED LIVING

Type of Survey (select all that apply)

2				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
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)
1. 35195	10/15/2019	10/17/2019	0.75	0.00	16.25	0.00	9.50	2.75
2.								
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**

DEC 02 2019

Oklahoma State Department of Health
Creating a State of Health

December 16, 2019

License Number: AL3801

Ms. Patricia Holt, Administrator
Woodland Gardens Assisted Living
915 North Broadway
Hobart, OK 73651

RE: Survey Event OPYK11

Dear Ms. Holt:

On October 17, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. 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 will be corrected and you will be in substantial compliance by **January 22, 2020**.

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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/ks

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/10/2019** **Facility Name:** Woodland Gardens Assisted Living **License Number:** AL3801 **Survey Event ID:** OPYK11 **Date Survey Completed: 10/17/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 711	Based on: This rule is not met as eveidenced by: Based on interview and record review, the center failed to ensure an annual fire marshall inspection was completed. This failed practice resulted in the widespread potential for more than minimal harm for all 11 residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be constructed as an admission of, or agreement with, the findings nd conculusions in the statement of defiencies, or any related sanctions or fines. Rather it is submitted as a confirmation of our ongoing efforts to comply with statuatory and regulatory requirements. In this document, we have outlinedspecific actions in response to identified issues. We remain commited to the delivery ofquality health services and will continue to make changes and improvements to satisfy this objective.

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 state fire marshall inspected the community on 10/24/2019 and the violations were corrected on 10/31/2019 and compliance was then obtained.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected by this deficient practice.
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 maintenance supervisor, C.O.O, and the administrator has put on each of the calandars when the the next fire marshal is to be scheduled. It is the duty of the maintenance supervisor, upon supervision of the administratorand COO, to ensure this is scheduled and completed yearly.
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.	Enter methods to ensure corrections are sustained: The C.O.O. meets with maintence weekly to discuss the weekly business. The C.O.O. will incorporate the yearly fire marschall inspection in her meetings as the date approaches. The QI committee will incorporate the yearly inspections in their quarterly meetings as the date approaches. Monitoring records will be maintained by the Administrator as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/10/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Patricia Hart Adm.	**Date 12/10/2019**
OAC 310:663-25-4(F)	

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/10/2019** **Facility Name:** Woodland Gardens Assisted Living **License Number:** AL3801 **Survey Event ID:** OPYK11 **Date Survey Completed: 10/17/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1923	Based on: This rule is not met as eveidenced by: Based on observation, interview, and record review, the center failed to ensure: a) Identity and signature of certified medication employees who administered medications to 6 (#1 through #6) of sampled residents were identified on MAR and b) Certified medication employees who administered as needed medications to 3 (#1,2, and #6) of 4 sampled residents recorded the date, time, dose, medication, and administration medthod on the MAR as required, These deficient practis=ces had the widespread potential for more than minimal harm to all 11 residents

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be constructed as an admission of, or agreement with, the findings nd conculusions in the statement of defiencies, or any related sanctions or fines. Rather it is submitted as a confirmation of our ongoing efforts to comply with statuatory and regulatory requirements. In this document, we have outlinedspecific actions in response to identified issues. We remain commited to the delivery ofquality health services and will continue to make changes and improvements to satisfy this objective.

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?	All medication staff were inserviced on 10/20/2019 regarding medication administration record and charting PRN medications
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents have the potential to be affected by this deficient practice
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?	MARs of all current residents will be monitored by the RN weekly for signatures and required charting. When compliance is obtained the audits will be completed monthly by the RN.
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.	The RN is responsible for sustained compliance. The RN will audit monitor all current MARs weekly to ensure signatures and required documentation by medication aides. Audit results will be reviewed monthly by the QI committee and the QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring records will be maintained by the administrator as evidence of correction.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/22/2020	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Joshua Holt Adm.			**Date 12/10/2019**
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
Creating a State of Health

February 11, 2020

License Number: AL3801

Ms. Patricia Holt, Administrator
Woodland Gardens Assisted Living
915 North Broadway
Hobart, OK 73651

RE: Survey Event OPYK12

Dear Ms. Holt:

On **January 23, 2020,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 17, 2019,** have now been corrected effective **January 22, 2020.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL3801	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND GARDENS ASSISTED LIVING	915 NORTH BROADWAY HOBART, OK 73651

(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 follow-up survey was conducted on 01/23/2020. Current census was 9. The deficient practices were cleared.	{C 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL3801	WOODLAND GARDENS ASSISTED LIVING

Type of Survey (select all that apply)

2	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
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)
1. 35195	01/23/2020	01/23/2020	0.25	0.00	1.00	0.00	4.75	0.50
2.								
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**