OKLAHOMA
State Department
of Health

**Delivery via email to:** pmiller@veradenlife.com

January 25, 2024

License Number: AL5545

Mr. Philip Miller, Administrator
The Veraden
2709 E Danforth Rd
Edmond, OK 73034

**Survey Event ID: 4DNI11**

Dear Mr. Miller:

On **December 29, 2023**, 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 represent the potential for no 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:

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: The Veraden**
**Address: 2709 E Danforth Rd**
**City, State, Zip:**
**Provider #: AL5545**
**Complaint #: OK00058530**
**Investigation Date(s): 12/27/23, 12/28/23 and 12/29/23**

## ALLEGATION(S)

The center failed to provide contracted services and failed to provide 3 meals a day.

An unannounced on-site investigation was initiated 12/27/2023 at 9:05a.m.

A sample of three 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:**

A tour of the facility was conducted upon entrance. Resident's rooms were observed for staff answering phones, call lights and prompting residents for meals.

Resident records were reviewed for contracted services for meals, resident council minutes, grievances and QAA/QAPI.

Residents were interviewed related to meal services and call lights

The attached Statement of Deficiencies, Form 2567 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: 01/03/2024

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility: The Veraden**
**Address: 2709 E Danforth Rd**
**City, State, Zip: Edmond, Ok**
**Provider #: AL5545**
**Complaint #: OK00059643**
**Investigation Date(s): 12/27/23, 12/2823 and 12/29/23**

## ALLEGATION(S)

| |
|---|
| The center failed to ensure the physician's orders were followed. |
| The center failed to notify resident's family regarding a change of condition. |
| The center failed to have a current license available for inspection. |
| The center failed to have activities that are relevant and valuable to the residents' quality of life |

An unannounced on-site investigation was initiated 12/27/2023 at 9:05 a.m.

A sample of three 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:**

A tour of the facility was conducted upon entrance. Resident halls were observed for safety practices with sharps containers. Staff were for prompting residents for activities.

Resident records were reviewed including physician order's, hospice notes, nursing notes, medication administration records, treatment records, activity schedules, resident council notes, grievances, resident contracts and facility license. Resident labs, incidents reports, QAPI/QAA reports, resident rosters and staff rosters were reviewed.

Residents were interviewed related to the provision of medication administration, activities and POA notifications.

The attached Statement of Deficiencies, Form 2567 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: 01/03/2024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5545 | A. BUILDING: _____ B. WING _____ | C 12/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE VERADEN | 2709 E DANFORTH RD EDMOND, OK 73034 |

| (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<br><br>Complaint investigations (#OK00059643 and #OK00058530) were conducted on 12/27/23, 12/28/23 and 12/29/23.<br><br>Facility Census: 96<br><br>Listed below are abbreviations used throughout this document.<br><br>DON- director of nursing<br>EMAR - electronic medication administration record<br>FSBS- finger stick blood sugar<br>MARS- medication administration records<br>MORS- Milestones of Recovery Scale | C 000 | | |
| C1923 SS=E | 310:663-19-2(a)(3) MEDICATION ADMINISTRATION<br><br>(3) An accurate written record of medications administered shall be maintained. The medication record shall include:<br>(A) The identity and signature of the person administering the medication.<br>(B) The medication administered within one hour of the scheduled time.<br>(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.<br>(D) Adverse reactions or results.<br>(E) Injection sites.<br>(F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident.<br>(G) Medication error incident reports. | C1923 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5545 | A. BUILDING: _____ B. WING _____ | C 12/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE VERADEN | 2709 E DANFORTH RD EDMOND, OK 73034 |

| (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<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to document FSBS results according to physician orders for three (#1, 2, and #3) of three sampled residents whose physician orders were reviewed.<br><br>The administrator identified 96 residents in the facility.<br><br>Findings:<br><br>The "Medication Assistance and MARs/MORs" policy, revised 04/23/2015, read in part, "...Medication assistance will be provided in accordance with state regulation. Medication Assistance includes reminding assisting, supervising, or administration of resident medications and treatments according to physician orders...All medication and treatment orders are to be transcribed onto the MAR/MOR EMAR. The MAR/MOR and Electronic MAR are a permanent part of the resident medical record...3. Confirmation with the Physician's Order: MAR/MOR, Electronic MARs are used for transcription of physician orders...To ensure order compliance , orders are recorded on MAR/MORs, Electronic MARs and will include resident name, medication name, dosage, frequency, non-medication orders, order date, signature and the initials of associates assisting with medications. Resident refusals will be noted on MAR/MOR, Electronic MAR...Resident medication and treatment refusals are documented on the MAR/MOR, Electronic MAR with a circle by the medication associate and the associate initials. Resident refusal and | C1923 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5545 | A. BUILDING: _____ B. WING _____ | C 12/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE VERADEN | 2709 E DANFORTH RD EDMOND, OK 73034 |

| (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 | C1923 | | |

information related to the reason is documented on the back of the MAR/MOR or typed in on the Electronic MAR..."

1. Res #1 had a diagnosis of diabetes.

The April 2022 EMAR documented a physicians order for FSBS one time per day every day at 9:00 a.m.

There was no FSBS documentation for eight times according to physician orders for the month of April 2022 in the Electronic MAR/MOR.

2. Res #2 had a diagnosis of diabetes.

The August 2022 EMAR documented a physician order for FSBS two times per day every day at 8:00 a.m. and 8 p.m.

There was no documentation thirteen times throughout the month of August 2022 in the Electronic MAR/MOR according to physicians order.

3. Res #3 had a diagnosis of diabetes.

The June, July, and August 2022 EMAR documented a physician orders for FSBS once per day every day at 9:00 a.m.

There was no documentation eleven times throughout the month of August 2022 in the EMARs/MORs according to physicians order.

On 12/28/23 at 4:36 p.m. the DON, they stated, "It looks like there are gaps in the FSBS for these residents."

On 12/28/23 at 4:41 p.m. the DON, they stated, "

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5545 | A. BUILDING: _____ B. WING _____ | C 12/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE VERADEN | 2709 E DANFORTH RD EDMOND, OK 73034 |

| (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<br>It looks like they are not done according to physician orders." | C1923 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** pmiller@veradenlife.com

February 1, 2024

License Number: AL5545

Mr. Philip Miller, Administrator/Executive Director
The Veraden
2709 E Danforth Rd
Edmond, OK 73034

**Survey Event ID: 4DNI11**

Dear Mr. Miller:

On **December 29, 2023**, 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:

- **C1923:** The plan of correction does not identify who will be responsible for pulling the weekly Yardi reports to ensure FSBS documentation has been completed.

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 1/31/2024**<br>**Facility Name:** The Veraden Assisted Living<br>**License Number:** AL5545<br>**Survey Event ID:** 4DNI11<br>**Date Survey Completed: 12/29/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C1923 | Based on: Record review and interview the facility failed to document FSBS results according to Physician orders for three (#1,#2,and #3) of three sampled residents whose physician orders were reviewed. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: This plan is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements in this document. In this document, we have outlined specific actions in response to each allegation or finding.

| **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 three residents identified (#1, #2, and #3) have all been discharged from our community and no longer reside at The Veraden. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | 1. The RSD or RSC will run a monthly report to include Residents with a Diabetes Diagnosis. The RSD or RSC will take the list of Residents with diagnosis of Diabetes and review their orders to verify FSBS orders. |
| 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? | 1. Residents who have diagnosis of Diabetes and Physician orders for The Community (The Veraden) to take and record FSBS will be documented in Yardi and logged in a binder kept at the Nurse's station.<br>2.The Advanced CMA/LPN will follow physician's orders for FSBS as prescribed and document results in Yardi and record also record FSBS results in binder. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Pull Yardi report weekly to ensure FSBS documentation has been completed.<br><br>Provide education to CMA/ACMA/LPNs on expectations of documentation requirements. Review policies related to: Physicians Orders, Medication Administration, FSBS<br><br>Review FSBS report results in QA<br><br>RSD and RSC will keep inservice education records and FSBS report records. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 2/14/2024 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | | | |
|---|---|---|---|
| **Administrator's Signature** Administrator signature required<br>OAC 310:663-25-4(F) | | | **Date 1/31/2024** |
| 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.<br>Facility in Compliance by: Click here to enter a date. | | | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** pmiller@veradenlife.com

February 8, 2024

License Number: AL5545

Mr. Philip Miller, Administrator
The Veraden
2709 E Danforth Rd
Edmond, OK 73034

**Survey Event ID: 4DNI11**

Dear Mr. Miller:

On **December 29, 2023,** 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 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 **February 14, 2024**.

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.

Respectfully,

Tempal Killman

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

Enclosure

| | |
|---|---|
| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 2/2/2024**<br>**Facility Name:** The Veraden Assisted Living<br>**License Number:** AL5545<br>**Survey Event ID:** 4DNI11<br>**Date Survey Completed: 12/29/2023** |

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: C1923 | Based on: Record review and interview the facility failed to document FSBS results according to Physician orders for three (#1,#2,and #3) of three sampled residents whose physician orders were reviewed. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: This plan is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements in this document. In this document, we have outlined specific actions in response to each allegation or finding.

| 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 three residents identified (#1, #2, and #3) have all been discharged from our community and no longer reside at The Veraden. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | 1. The RSD or RSC will run a monthly report to include Residents with a diabetes diagnosis. The RSD or RSC will take the list of Residents with diagnosis of Diabetes and review their orders to verify FSBS orders. |
| 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? | 1. Residents who have diagnosis of Diabetes and Physician orders for The Community (The Veraden) to take and record FSBS will be documented in Yardi and logged in a binder kept at the Nurse's station.<br>2.The Advanced CMA/LPN will follow physician's orders for FSBS as prescribed and document results in Yardi and record also record FSBS results in binder. The RSD or RSC will create the binder, and ensure that residents with a diabetes diagnosis are logged in the binder.<br>3.The RSD or RSC will pull Yardi report weekly to ensure FSBS documentation has been completed. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | The RSD or RSC will pull Yardi report weekly to ensure FSBS documentation has been completed.<br><br>The ED or RSD will provide education to CMA/ACMA/LPNs on expectations of documentation requirements. Review policies related to: Physicians Orders, Medication Administration, FSBS<br><br>The ED or RSD will review FSBS report results in QA |

| | | | |
|---|---|---|---|
| | RSD and RSC will keep inservice education records and FSBS report records. | | |
| OSDH Response: Element accepted Yes ☐ No ☐ | | | |
| 5. On what date will corrective action be completed? | 2/14/2024 | | |
| OSDH Response: Element accepted Yes ☐ No ☐ | | | |
| **Administrator's Signature** OAC 310:663-25-4(F) Philip Miller | | **Date 2/2/2024** | |
| 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** | 2/2/2024 | **Submitted by** | Philip Miller |
| 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. | | | |