Oklahoma State Department of Health
Creating a State of Health

October 9, 2019

License Number: AL6601

Ms. Crystal Haff-Jones, Administrator
Brookdale Claremore
1605 North Highway 88
Claremore, OK 74017

RE: Survey Event ID: EVUO11

Dear Ms. Haff-Jones:

On **September 20, 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 September 20, 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,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL6601	A. BUILDING: _____ B. WING _____	09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CLAREMORE	1605 NORTH HIGHWAY 88 CLAREMORE, OK 74017

(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
N 000	Initial Comments A re-licensure survey was conducted on 09/17/19 through 09/20/19. Current census was 58. Deficient practice was cited as follows.	N 000		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure certified medication aide's (CMA) skills were validated prior to administering medications for 4 (#6 through #9) of six sampled CMAs who were hired since this the last survey. This failed practice had the potential for more than minimal harm at a pattern. Findings: The employee files were reviewed and revealed the following CMAs had not had their skills validated prior to administering medications: CMA/employee #6 - hired 07/22/19; CMA/employee #7 - hired 10/29/18; CMA/employee #8 - hired 06/19/19; and CMA/employee #9 - hired 09/25/18. Medication error reports were reviewed. Employee #6 omitted three medications for three	N1442		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6601	A. BUILDING _____ B. WING _____	09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CLAREMORE	1605 NORTH HIGHWAY 88 CLAREMORE, OK 74017

(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
N1442	Continued From page 1 residents during a medication pass on 07/29/19. Her skills were validated on 07/30/19. Employee #8 administered the wrong medication to the wrong resident on 07/30/19. Employee #8's skills were validated on 08/05/19. Employee #9 administered the wrong medication to the wrong resident on 07/21/19. The employee's skills were validated on 08/14/19. On 09/20/19 at 11:01 a.m., licensed practical nurse (LPN) #2 stated the skills validations were not done when she came to work at the center.	N1442		
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 09/17/19 through 09/20/19. Current census was 58. Deficient practice was cited as follows.	C 000		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure medications were administered by qualified staff. This failed practice had the potential for more	C 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6601	A BUILDING _____ B WING _____	09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CLAREMORE	1605 NORTH HIGHWAY 88 CLAREMORE, OK 74017

(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 921	Continued From page 2 than minimal harm at a pattern. Findings. Employee files were reviewed. Employee #5 did not have a current certification to administer medication. The assistant administrator stated the certification expired on 05/31/19 and employee #5 was not administering medications. Medication administration records (MAR) for seven residents were reviewed. The records documented employee #5 administered medication on 09/01/19 and 09/09/19. A competency checklist for employee #5, dated 09/01/19, documented employee #5 had successfully demonstrated the skills for application of transdermal patches, administering eye/ear drops/ointments, topical medications, nasal sprays, and liquid medication via return demonstration to the nurse. (The employee did not have a current certification to administer medication.) On 09/19/19 at 10:16 a.m., licensed practical nurse #1 reviewed the MARs and stated she supposed employee #5 had administered medications on 09/01/19 and 09/09/19. She stated the employee went to an update class and failed to submit the required money to obtain the certification to administer medication. Policy: The center's policy for medication and treatment, dated 03/2018, documented, "...Trained and/or licensed associates may administer or assist the resident with...medication administration and treatments...per state regulation..."	C 921		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL6601	BROOKDALE CLAREMORE

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. 36191	09/17/2019	09/20/2019	1.00	0.00	25.50	0.00	9.00	4.00
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**

OCT 10 2019 jm

Oklahoma State Department of Health
Creating a State of Health

October 16, 2019

License Number: AL6601

Ms. Crystal Haff- Jones, Administrator
Brookdale Claremore
1605 North Highway 88
Claremore, OK 74017

RE: Survey Event EVUO11

Dear Ms. Jones:

On September 20, 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 **October 31, 2019**.

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: 10/10/2019** **Facility Name:** Brookdale Claremore **License Number:** AL6601 **Survey Event ID:** EVUO11 **Date Survey Completed: 9/20/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C921	Based on: C921 Medication Staffing- Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following Plan of Correction for Brookdale Claremore regarding the statement of deficiencies date 9/20/2019. The plan of correction is not to be construed as an admission or agreement with the findings and the conclusion in the statement of deficiencies, or any related to sanction or fine. Rather, it is submitted as confirmation of our ongoing effort to comply with regulatory and statutory requirements. In this document, we have outlined specific action in response to identified issues. We have not provided a detailed response in allegation or finding, nor have we identified mitigating factors. We remain committed to deliver of quality heath services and will continue to make changes as improvements to satisfy objectives.

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?	Associate will have skills competencies completed upon hire and annually. Brookdale Claremore will follow the state and Brookdale Standards for competencies and review. Associates will be verified frequently to ensure licensure is compliant with policies and state standards. Associates will complete the medication skills check off before passing medications to residents and this will include verification of licensure. Associate Executive Director or Executive Director will check compliance periodically. Pharmacy consultant will come in quarterly and doing audit which will include the med pass audit.
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 deficient practices will be identified when the random audits that are completed for compliance.
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?	This will be added to the monthly QA and random audits will occur monthly & Quarterly with QA. Pharmacy Consultant and RN to review and sign. Brookdale Claremore will also institute a tracking form to keep track of credentials, updates and expirations dates which includes the Certifed Medication Aides and Certified Nurse Aides.
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	Enter methods to ensure corrections are sustained: Random audits and documentation of credentials and the document is sent to the ED monthly to ensure compliance. Community will QA as required by state which will also include the inservices, medication trainings and

center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	interventions as needed. Staff credential tracker and random audits of the skills check off.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/31/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Kari Willard OAC 310:663-25-4(F)	**Date 10/14/2019**

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/10/2019** **Facility Name:** Brookdale Claremore **License Number:** AL6601 **Survey Event ID:** EVUO11 **Date Survey Completed: 9/20/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: N1442, C921	Based on: N1442-Skills and Functions, The facility, center or home shall validatecertified medication aide skills before the certified medication aide performs medication administration. The certified medication aides'skills shall be reviewed annually for performance competency.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following Plan of Correction for Brookdale Claremore regarding the statement of deficiencies date 9/20/2019. The plan of correction is not to be construed as an admission or agreement with the findings and the conclusion in the statement of deficiencies, or any related to sanction or fine. Rather, it is submitted as confirmation of our ongoing effors to comply with regulatory and statutory requirements. In this document, we have outlined specific action in response to identified issues. We have not provided a detailed response in allegation or finding, nor have we identified mitigating factors. We remain committed to deliver of quality heath services and will continue to make changes as improvements to satisfy objectives.

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?	Associate will have skills competencies completed upon hire and annually. Brookdale Claremore will follow the state and Brookdale Standards for competencies and review. Associates will be verified frequently to ensure licensure is compliant with policies and state standards. Associates will complete the medication skills check off before passing medications to residents and this will include verification of licensure. Associate Executive Director or Executive Director will check compliance periodically.
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 deficient practices will be identified when the random audits that are completed for compliance.
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?	This will be added to the monthly QA and random audits will occur monthly. Brookdale Claremore will also institute a tracking form to keep track of credentials, updates and expirations dates.
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: Random audits and documentation of credentials and the document is sent to the ED monthly to ensure compliance. Community will QA as required by state which will also include the inservices, medication trainings and interventions as needed. Staff credential tracker and random audits of the skills check off.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/31/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Kari Willard** OAC 310:663-25-4(F)			**Date 10/14/2019**
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

December 13, 2019

License Number: AL6601

Ms. Crystal Hoff-Jones, Administrator
Brookdale Claremore
1605 North Highway 88
Claremore, OK 74017

RE: Survey Event EVUO12

Dear Ms. Hoff-Jones:

On **November 15, 2019,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 20, 2019,** have now been corrected effective **October 31, 2019.**

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
	AL6601	A. BUILDING _____ B. WING _____	R 11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CLAREMORE	1605 NORTH HIGHWAY 88 CLAREMORE, OK 74017

(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
{N 000}	Initial Comments A follow-up survey was conducted on 11/15/19. Current census was 57. The deficient practice was cleared.	{N 000}		
{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 11/15/19. Current census was 57. The deficient practice was 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
AL6601	BROOKDALE CLAREMORE

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)
Team Leader ID 1. [illegible] 25837	11/15/2019	11/15/2019	0.25	0.00	1.00	0.00	3.00	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**