



Oklahoma State Department of Health
Creating a State of Health

November 26, 2019

License Number: AL7264

Mr. Garrett Lee, Administrator
Covenant Living Of Bixby
7300 East 121st Place South
Bixby, OK 74008

RE: Survey Event ID: S39H11

Dear Mr. Lee:

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;

Board of Health

Gary Cox, JD
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(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

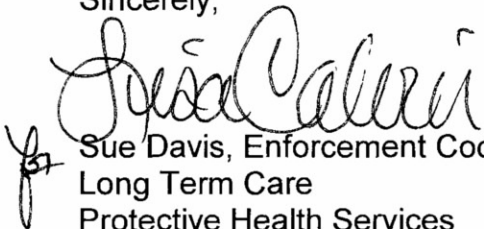
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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,

A handwritten signature in cursive script, appearing to read "Sue Davis".

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 10/17/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COVENANT LIVING OF BIXBY

**7300 EAST 121ST PLACE SOUTH
BIXBY, OK 74008**

(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 10/16/19 and 10/17/19. The resident census was 34. The following deficient practice was cited.	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: The center failed to ensure food preparation equipment was clean and not exposed to contamination according to Chapter 257. These failed practices had the potential for more than minimal harm for all 34 residents who received their nutrition from the kitchen. Findings: On 10/17/19 at 11:30 a.m., a tour of the kitchen was conducted with the assistance of staff. 310:257-5-31. In-use utensils, between-use storage (2) In food that is not Time/Temperature Control for Safety Food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon; - the scoop was observed found inside the flour bin. - a scoop was observed inside the panko bread crumbs sack. 310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces and utensils	C 391		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL7264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/17/2019
NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF BIXBY			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 EAST 121ST PLACE SOUTH BIXBY, OK 74008		
(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 391	Continued From page 1 (a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. - the flour bin was dirty with food spillage. - food debris and splatters were observed on the floor of the freezer - the wall by the handwashing sink and the trash bin was observed dirty with food spillage. - the door to the mop closet was observed soiled with food spillage. - the door to the warmer box was observed to be soiled with food spillage, on the front and sides. - an accumulation of thick, brown, burned on grease was observed down the front of the cooking stove, and the floor had dried debris. 310:257-7-85 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. - an accumulation of dust, grease and debris was observed on top of the stove hood. At 11:35 a.m., staff stated, "yes I see the dirt on the door and floor."	C 391			

STATE WORKLOAD REPORT

Provider/Supplier Number AL7264	Provider/Supplier Name COVENANT LIVING OF BIXBY
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Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| 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				
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- 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 <i>SV</i>								
1. 32388	10/16/2019	10/17/2019	0.50	0.00	9.00	0.00	5.00	0.50
2. 18273 <i>SV</i>	10/16/2019	10/17/2019	0.50	0.00	9.00	0.00	4.00	3.00
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
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Total SA Clerical/Data Entry Hours....	0.00	Total RO Clerical/Data Entry Hours....	0.00
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Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

NOV 26 2019 *jm*



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/26/2019

Facility Name: Covenant Living of Bixby

License Number: AL – 7264

Survey Event ID: S39H11

Date Survey Completed: 10/17/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: The center failed to ensure food preparation equipment was clean and not exposed to contamination according to Chapter 257. These failed practices had the potential for more than minimal harm for all 34 residents who received their nutrition from the kitchen.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The enclosed Plan of Correction should constitute our credible allegation of compliance and we trust you will find it adequate and acceptable. This Plan of Correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Facility as to the accuracy of the surveyors' findings nor the conclusions drawn therefrom. The Facility's submission of this Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

- Facility identified corrective action needed to address the deficient practices and began implementing those action items immediately during and upon completion of the survey inspection.
- Each dining team member received a re-education coaching outlining the expectations involving cleaning.
- A mandatory dining staff meeting was held on 10-22-19 at 2:30pm. Each item identified during survey was discussed at this meeting and the plan to address each item was reviewed.
- The kitchen floor and the cooler floor and walls were professionally steam cleaned by a local commercial cleaning company on 10-30-19.
- Bin scoops were removed.
- Master weekly cleaning lists were updated on 10-22-19 to include the cleaning of the bins/lids, walls, and staff was re-educated same day.
- The wall by the handwashing sink and the trash bin was cleaned immediately and the lids are being run routinely through the dishwasher.
- The door to the mop closet was cleaned immediately.
- The door to the warmer box was cleaned immediately.
- The front of the cooking stove was cleaned immediately. and the dried debris on the floor was swept, scrubbed and mopped.
- The stove hood was cleaned immediately.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

- Since this citation was a SS F, it is assumed that all residents were affected similarly by the deficient practice,

		therefore, the Facility believes that the corrective action items addressed in question 1 above are sufficient to mitigate any future impact to residents for the same 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 floors are swept and mopped daily by the am and pm Cooks. - The cleaning of the walls has been clarified on the weekly master cleaning lists. - The cleaning of the bins has been clarified on the master cleaning list. - Bin scoops were removed immediately while the surveyor was present and scoops will not be placed inside the bins. - Door cleaning was clarified on the weekly master cleaning schedule. - Stove and hood cleaning was also clarified on the weekly master cleaning schedule.
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.		A. The staff member completing the cleaning tasks will sign off on the master cleaning schedule once they've completed that days cleaning. B. The Dining Services Director will do weekly audits of the master cleaning schedule. C. The Facility will monitor effectiveness of the above interventions by the quarterly inspections performed by the Sanitarian of the local health dept. These reports will be taken to the qtrly QA meeting and tracked. D. The master cleaning schedules will be signed and filed by the Dining Services Director; the QA minutes will continue to be maintained by the Assisted Living Director. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		11/30/2019
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Administrator signature required.		Date Enter a date of signature.
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7264	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/17/2019
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Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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Oklahoma State Department of Health
Creating a State of Health

January 14, 2020

License Number: AL7264

Mr. Garrett Lee, Administrator
Covenant Living Of Bixby
7300 East 121st Place South
Bixby, OK 74008

RE: Survey Event S39H12

Dear Mr. Lee:

On **January 7, 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 **November 30, 2019**.

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

Sincerely,

Katie Hagner

for

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7264	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B WING _____	(X3) DATE SURVEY COMPLETED R 01/07/2020
NAME OF PROVIDER OR SUPPLIER COVENANT LIVING OF BIXBY		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 EAST 121ST PLACE SOUTH BIXBY, OK 74008		
(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 01/07/2020. Resident census was 35. Deficient practice was cleared.	{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
AL7264

Provider/Supplier Name
COVENANT LIVING OF BIXBY

Type of Survey (select all that apply)

2	D			
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- | | | |
|---------------------------|-------------------------|---------------------|
| 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. 34460	01/07/2020	01/07/2020	0.50	0.00	0.75	0.00	1.50	0.50
2.								
3.								
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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