VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 23, 2026

Anne Steinberg
Michaud Memorial Manor
47 Herrick Road
Derby Line, VT 05830-8759

Dear . Steinberg:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 22, 2026.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,



Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0143	A. BUILDING: _____ B. WING _____	C 06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

(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
R100	Initial Comments On 6/22/2026 the Division of Licensing and Protection conducted an unannounced on-site investigation of 2 complaint and 1 facility reported incidents. The following regulatory deficiencies were identified:	R100		
R172 SS=F	5.9.c.(15) Nursing Services For each resident requiring nursing overview, administration of medication, or nursing care, the registered nurse must: Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home?s policies. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the Director of Nursing failed to ensure medications are administered in accordance with the home's policies and procedures. Findings include: The home's Medication Administration Policy (effective date not listed) states this policy is "To ensure safe and effective medication practices by outlining procedures for preparation, administration and documentation, focusing on the "rights" of medication administration and emphasizing resident safety." This policy states "The Registered Nurse must accept responsibility for proper administration of medications ..." and identifies the Registered Nurse's responsibilities including teaching designated staff proper techniques for medication administration; and monitoring and evaluating the designated staff performance in conducting the nurse's	R172		

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R172	Continued From page 1 instructions. The procedures listed in this policy states all nursing staff must adhere to guidelines which include : 1. All staff who are working on the med cart are responsible for counting the narcotics at the beginning and end of each shift and documenting their completion of the count. If the count is off, the applicable staff are required to immediately report this finding to the Director of Nursing and/or the on-call nurse, and remain in the building until the discrepancy in the count is resolved. Controlled substances were not handled in accordance with this policy by facility Med Techs as evidenced by: Per staff interview and record review, during the 2 PM controlled substance count on 4/25/2026 a discrepancy in the number of Oxycodone 5 mg tablets belonging to Resident #1 stored in the med cart did not match the number of pills recorded on the controlled substance inventory list. In response to this finding, the Administrator and Director of Nursing conducted an investigation and determined the medication was was missing from the med cart and could not be accounted for. Per staff interview and record review, during the investigation process it was discovered that the Med Techs responsible for conducting the controlled substance counts during shift changes on 4/24/2026 and 4/25/2026 failed to ensure both the incoming and outgoing Med Techs visually observed and confirmed that the number of pills in stock matched the number of pills listed on the inventory list. At 11:47 AM on 6/22/2026 the Administrator confirmed all med delegated staff who	R172		

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R172	Continued From page 2 participated in the controlled substance counts conducted on 4/24/2026 and 4/25/2026 were not following the policies and procedures for controlled counts as they were not cross checking each other to confirm the amount in the med cart matched the amount reported to be in stock in order to confirm the counts were accurate. At 1:09 PM on 6/22/2026 the Director of Nursing confirmed they had trained all staff to perform controlled substance counts in person and confirmed the staff responsible for performing these counts were taking short cuts and not double checking each other during the count process. Additionally, per staff interview, there was a failure to ensure the Med Techs conducting the controlled substance count on the afternoon of 4/25/2026 remained on site until the discrepancy was resolved. During the interview at 1:09 PM on 6/22/2026 the Director of Nursing confirmed they were notified regarding the Oxycodone count discrepancy when it was discovered on the afternoon of Saturday 4/25/2026; however, they did not determine if the Oxycodone count could be reconciled until Monday 4/27/2026. The Director of Nursing stated this delay occurred because when previous discrepancies occurred the meds were found. Per the Director of Nursing, med count documentation errors had been an issue for a couple of weeks prior to this incident because the staff was adjusting to using an electronic method of documenting controlled substance counts. 2. Procedures listed in the home's Medication Administration policy also state that nursing staff, which includes delegated Med Techs, Registered Nurses and the Director of Nursing, will use the 6	R172		

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R172	Continued From page 3 medication Rights to accurately administer medications. The 6 Medication Rights listed in the procedures section of this policy include: a. "Right Medication (read label 3 times)" b. "Right Dose (Check math, MAR, and label)" c. "Right Resident (Check MAR, label, picture of resident)" d. "Right Time (check MAR and label)" e. "Right Route (oral, injection, topical,etc)" f. "Right Documentation" The home's policy and procedures for Accuracy In Administration Of Medication states is the responsibility of the staff person assigned to medications to see that the "right dose" of the "right medication" is given to the "right person" at the "right time" by the "right method" and the "right documentation"; and states each medication is to be checked against the electronic medication administration record before pouring the medication. Medications were not administered in accordance with these policies as evidenced by: Per interview with the Director of Nursing commencing at 12:53 PM on 6/22/2026, and per record review, during a period of five months medications were not administered as ordered by 4 delegated Med Techs and 3 Registered Nurses including the former and the current Directors of Nursing. Between 1/10/2026 and 5/11/2026 sixteen medication errors occurred including: a. On 1/10/2026 and 1/11/26 Resident #1 was given 20 mg of Prednisone when 60 mg was ordered. b. On 1/26/2026 Resident #2 was not given their scheduled Colace 100 mg capsule at bedtime as	R172		

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R172	Continued From page 4 ordered. c. On 3/17/2026 Resident #3 was not given their scheduled 8 AM dose of Clonazepam. d. On 3/24/2026 and 3/26/2026 Resident #4 was given 1300 mg of Acetaminophen at 8:00 PM when 650 mg was scheduled to be given. e. On 4/1/2026 Resident #5 was given their 0.5 mg dose of Lorazepam scheduled for 4:00 PM late during the bedtime med pass. f. On 4/4/2026 Resident #5 given 0.25 mg of Lorazepam at 4:00 PM when 0.5 mg was ordered. This medication error was made by the same Med Tech responsible for the medication error on 4/1/2026 listed above. g. The following medication errors were made on 4/24/2026 and 4/25/2026 by a Med Tech who performed their first independent med pass after delegation on 4/24/2026: * On 4/24/2026 and 4/25/2026 Resident #6 was given 1 tablet of Sodium Chloride when 2 tablets were ordered. * On 4/24/2026 Resident #7 was given 150 mg of Pregabalin (medication for nerve pain) when 300 mg was prescribed. * On 4/24/2026 Resident #8 was given 500 mg of Acetaminophen when 1000 mg was ordered. This is not documented in the Medication Administration Record. * On 5/4/2026 Resident #9's scheduled 5 mg dose of Olanzapine was not given.	R172		

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R172	Continued From page 5 * On 5/11/2026 Resident #10 was not given their morning medications which included Metoprolol 50 mg, Stool Softener 50 mg (1/2 of a 100 mg tab) and Vit D3 2000 IU h. On 5/5/2026 Resident #6's Lyrica 25 mg dose scheduled to be given one hour prior to bedtime was given at noon. i. On 5/6/2026 - Resident #7 was given 150 mg of Pregabalin (medication for nerve pain) when 300 mg was prescribed These findings were confirmed by the Director of Nursing during a review of medication errors on the afternoon of 6/22/2026. Please refer to tags 190 and 209.	R172		
R190 SS=F	5.10.b Medication Management The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Manager failed to ensure all medications are handled according to the home's policies. Findings include: The home's Medication Administration Policy (effective date not listed) states this policy is "To ensure safe and effective medication practices by outlining procedures for preparation,	R190		

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R190	Continued From page 6 administration and documentation, focusing on the "rights" of medication administration and emphasizing resident safety." The procedures listed in this policy states all nursing staff must adhere to guidelines which include : 1. All staff who are working on the med cart are responsible for counting the narcotics at the beginning and end of each shift and documenting their completion of the count. If the count is off, the applicable staff are required to immediately report this finding to the Director of Nursing and/or the on-call nurse, and remain in the building until the discrepancy in the count is resolved. Controlled substances were not handled in accordance with this policy by facility Med Techs as evidenced by: Per staff interview and record review, during the 2 PM controlled substance count on 4/25/2026 a discrepancy in the number of Oxycodone 5 mg tablets belonging to Resident #1 stored in the med cart did not match the number of pills recorded on the controlled substance inventory list. In response to this finding, the Administrator and Director of Nursing conducted an investigation and determined the medication was was missing from the med cart and could not be accounted for. Per staff interview and record review, during the process of investigating this discrepancy it was discovered that the incoming and outgoing Med Techs responsible for conducting the controlled substance counts on 4/24/2026 and 4/25/2026 were not cross checking each other to confirm the amount in the med cart matched the amount reported to be in stock in order to confirm the counts were accurate.	R190		

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R190	Continued From page 7 This finding was confirmed by the Administrator at 1:47 AM on 6/22/2026 and by the Director of Nursing at 1:09 PM on 6/22/2026. Per staff interview, there was also a failure to ensure Med Techs conducting the controlled substance count on the afternoon of 4/25/2026 remained on site until the discrepancy was resolved. During the interview at 1:09 PM on 6/22/2026 the Director of Nursing confirmed they were notified regarding the Oxycodone count discrepancy when it was discovered on the afternoon of Saturday 4/25/2026; however, they did not determine if the Oxycodone count could be reconciled until Monday 4/27/2026. Per the Director of Nursing, med count documentation errors had been an issue for a couple of weeks prior to this incident, and when these discrepancies occurred the medications thought to be missing were in the cart. 2. Procedures listed in the home's Medication Administration policy also state that nursing staff, which includes delegated Med Techs, Registered Nurses and the Director of Nursing, will use the 6 medication Rights to accurately administer medications. The 6 Medication Rights listed in the procedures section of this policy include: a. "Right Medication (read label 3 times)" b. "Right Dose (Check math, MAR, and label)" c. "Right Resident (Check MAR, label, picture of resident)" d. "Right Time (check MAR and label)" e. "Right Route (oral, injection, topical,etc)" f. "Right Documentation" The home's policy and procedures for Accuracy In Administration Of Medication states is the responsibility of the staff person assigned to	R190		

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R190	Continued From page 8 medications to see that the "right dose" of the "right medication" is given to the "right person" at the "right time" by the "right method" and the "right documentation"; and states each medication is to be checked against the electronic medication administration record before pouring the medication. Medications were not administered in accordance with these policies as evidenced by: Per interview with the Director of Nursing commencing at 12:53 PM on 6/22/2026, staff including 4 delegated Med Techs and 3 Registered Nurses made a combined total of sixteen medication errors between 1/10/2026 and 5/11/2026 including: a. On 1/10/2026 and 1/11/26 Resident #1 was given 20 mg of Prednisone when 60 mg was ordered. b. On 1/26/2026 Resident #2 was not given their scheduled Colace 100 mg capsule at bedtime as ordered. c. On 3/17/2026 Resident #3 was not given their scheduled 8 AM dose of Clonazepam. d. On 3/24/2026 and 3/26/2026 Resident #4 was given 1300 mg of Acetaminophen at 8:00 PM when 650 mg was scheduled to be given. e. On 4/1/2026 Resident #5 was given their 0.5 mg dose of Lorazepam scheduled for 4:00 PM late during the bedtime med pass. f. On 4/4/2026 Resident #5 given 0.25 mg of Lorazepam at 4:00 PM when 0.5 mg was ordered. This medication error was made by the	R190		

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R190	Continued From page 9 same Med Tech responsible for the medication error on 4/1/2026 listed above. g. The following medication errors were made on 4/24/2026 and 4/25/2026 by a Med Tech who performed their first independent med pass after delegation on 4/24/2026: * On 4/24/2026 and 4/25/2026 Resident #6 was given 1 tablet of Sodium Chloride when 2 tablets were ordered. * On 4/24/2026 Resident #7 was given 150 mg of Pregabalin (medication for nerve pain) when 300 mg was prescribed. * On 4/24/2026 Resident #8 was given 500 mg of Acetaminophen when 1000 mg was ordered. * On 5/4/2026 Resident #9's scheduled 5 mg dose of Olanzapine was not given. On 5/11/2026 Resident #10 was not given their morning medications which included Metoprolol 50 mg, Stool Softener 50 mg (1/2 of a 100 mg tab) and Vit D3 2000 IU h. On 5/5/2026 Resident #6's Lyrica 25 mg dose scheduled to be given one hour prior to bedtime was given at noon. i. On 5/6/2026 - Resident #7 was given 150 mg of Pregabalin (medication for nerve pain) when 300 mg was prescribed These findings were confirmed by the Director of Nursing during a review of medication errors on the afternoon of 6/22/2026. Please refer to tags 172 and 209.	R190		

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R209 SS=F	5.11.b Staff Services The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review staff failed to demonstrate competencies in the skills they are required to perform including performing controlled substance medication counts and administering medications as ordered. Findings include: 1. Per the home's Medication Administration Policy all staff who are working on the med cart are responsible for counting the narcotics at the beginning and end of each shift and documenting their completion of the count. If the count is off, the applicable staff are required to immediately report this finding to the Director of Nursing and/or the on-call nurse, and remain in the building until the discrepancy in the count is resolved. Staff failed to demonstrate competency in conducting controlled substance medication counts as evidenced by: Per staff interview and record review, during an investigation conducted at the home which confirmed an Oxycodone 5 mg tablet belonging to Resident #1 was missing, it was discovered that the incoming and outgoing Med Techs responsible for conducting the controlled substance counts on 4/24/2026 and 4/25/2026 were not cross checking each other to confirm	R209		

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R209	Continued From page 11 the amount in the med cart matched the amount reported to be in stock in order to confirm the counts were accurate. This finding was confirmed by the Administrator at 1:47 AM on 6/22/2026 and by the Director of Nursing at 1:09 PM on 6/22/2026 2. Procedures listed in the home's Medication Administration policy also state that nursing staff, which includes delegated Med Techs, Registered Nurses and the Director of Nursing, will use the 6 medication Rights to accurately administer medications. The 6 Medication Rights listed in the procedures section of this policy include: a. "Right Medication (read label 3 times)" b. "Right Dose (Check math, MAR, and label)" c. "Right Resident (Check MAR, label, picture of resident)" d. "Right Time (check MAR and label)" e. "Right Route (oral, injection, topical,etc)" f. "Right Documentation" The home's policy and procedures for Accuracy In Administration Of Medication states is the responsibility of the staff person assigned to medications to see that the "right dose" of the "right medication" is given to the "right person" at the "right time" by the "right method" and the "right documentation"; and states each medication is to be checked against the electronic medication administration record before pouring the medication. Staff failed to demonstrate competency in using the 6 medication Rights to administer medications as ordered as evidenced by: Per staff interviews and record review, between	R209		

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R209	Continued From page 12 1/10/2026 and 5/11/2026 staff including 4 delegated Med Techs and 3 Registered Nurses made a combined total of 16 medication errors. These medication errors included staff administering the wrong dose, failing to administer medications, and giving medication at the wrong time. These findings were confirmed by the Director of Nursing during a review of medication errors on the afternoon of 6/22/2026. Please refer to tags 172 and 190.	R209		
R223 SS=D	5.12.b (2) Records/Reports The home must keep and maintain the following records. A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; licensed health care provider ' s name, address and telephone number; instructions in case of resident ' s death; the resident ' s assessment(s); progress notes regarding any accident or incident and subsequent follow-up; progress notes regarding any illness or change in condition and subsequent related follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident ' s advance directives, if any completed; and a copy of the document giving legal authority to another, if any.	R223		

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MICHAUD MEMORIAL MANOR	47 HERRICK ROAD DERBY LINE, VT 05830

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R223	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review there is a failure to document an incident in one applicable resident's record (Resident #11). Findings include: During an interview commencing at 4:44 PM on 6/22/2026, the Administrator and Director of Nursing confirmed an incident had occurred during which a Staff placed Resident #11 on the toilet then left the facility without notifying the staff on duty know Resident #11 was unattended on their toilet. The Administrator and Director of Nursing confirmed Resident #11 required staff assistance with toileting, was left unattended on their toilet for an extended period of time, and was found to have red marks on their bottom when found. On the afternoon of 6/22/2026 the Administrator and Director of Nursing confirmed there is no documentation of this incident and actions taken in response to this incident in Resident #11's record. The Administrator was unable to provide information regarding this incident on request including the date the incident occurred and the length of time Resident #11 was left on the toilet.	R223		

Deficiency Statement Plan of Correction (POC)

(Please use additional pages if needed)

DLP Use Only:

Survey Date: 6/22/26

Facility Name: Michaud Memorial Manor

Deficiency Tag:	R172
How the deficiency was corrected:	All nursing staff, including Med Techs and licensed nurses, were re-educated on the facility policy for narcotic count procedures and what to do in the event of a missing narcotic on April 27, 2026 and this will be reviewed again at a nursing meeting on July 23, 2026. Additionally, all med techs and licensed nurses will be re-educated on the 6 medication rights for administering medications on 7/23/2026. The facility also transitioned to the use of bingo cards (single med cards) instead of comingles (multi-med cards) on July 3, 2026 with the intent of minimizing the potential for errors.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	The Director of Nursing conducted daily narcotic counts to verify accuracy on 4/30, 5/4, 5/5, 5/6, 5/7, 5/8 and 5/11 and weekly counts thereafter to ensure that there were no additional missing narcotic issues.
System changes to ensure compliance with the regulation:	Narcotic count procedures and medication rights for administering medications will be reviewed at all monthly nursing meetings for 6 months and nursing staff will be randomly questioned to ensure understanding of the policies. All medication error reports are reviewed weekly by the Director of Nursing and the Administrator to ensure the staff member making the error has had adequate education/retraining as needed, and all medication errors are reviewed at the quarterly QA meeting. The facility transitioned to the use of bingo cards (single med cards) instead of comingles (multi-med cards) on July 3, 2026 with the intent of minimizing the potential for errors. To date, there have been no medication errors under the new bingo card system. The Director of Nursing has purchased new training materials which will be used to enhance the already existing training that is given to new Med Aides.
Date corrected:	7/23/26
Who will monitor to ensure compliance:	Director of Nursing
DLP Use Only	R172 Plan of Correction accepted by Jo A Evans, RN on 7/22/2026

Survey Date: 6/22/26

Facility Name: Michaud Memorial Manor

Deficiency Tag:	R190
How the deficiency was corrected:	All nursing staff, including Med Techs and licensed nurses, were re-educated on the facility policy for narcotic count procedures and what to do in the event of a missing narcotic on April 27, 2026 and this will be reviewed again at a nursing meeting on July 23, 2026. Additionally, all med techs and licensed nurses will be re-educated on the 6 medication rights for administering medications on 7/23/2026. The facility also transitioned to the use of bingo cards (single med cards) instead of comingles (multi-med cards) on July 3, 2026 with the intent of minimizing the potential for errors.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	The Director of Nursing conducted daily narcotic counts to verify accuracy on 4/30, 5/4, 5/5, 5/6, 5/7, 5/8 and 5/11 and weekly counts thereafter to ensure that there were no additional missing narcotic issues.
System changes to ensure compliance with the regulation:	Narcotic count procedures and medication rights for administering medications will be reviewed at all monthly nursing meetings for 6 months and nursing staff will be randomly questioned to ensure understanding of the policies. All medication error reports are reviewed weekly by the Director of Nursing and the Administrator to ensure the staff member making the error has had adequate education/retraining as needed, and all medication errors are reviewed at the quarterly QA meeting. The facility transitioned to the use of bingo cards (single med cards) instead of comingles (multi-med cards) on July 3, 2026 with the intent of minimizing the potential for errors. To date, there have been no medication errors under the new bingo card system. The Director of Nursing has purchased new training materials which will be used to enhance the already existing training that is given to new Med Aides.
Date corrected:	7/23/26
Who will monitor to ensure compliance:	Director of Nursing
DLP Use Only	R190 Plan of Correcion accpeted by Jo A Evans, RN on 7/22/2026

Survey Date: 6/22/26

Facility Name: Michaud Memorial Manor

Deficiency Tag:	R209
How the deficiency was corrected:	All nursing staff, including Med Techs and licensed nurses, were re-educated on the facility policy for narcotic count procedures and what to do in the event of a missing narcotic on April 27, 2026 and this will be reviewed again at a nursing meeting on July 23, 2026. Additionally, all med techs and licensed nurses will be re-educated on the 6 medication rights for administering medications on 7/23/2026. The facility also transitioned to the use of bingo cards (single med cards) instead of comingles (multi-med cards) on July 3, 2026 with the intent of minimizing the potential for errors.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	The Director of Nursing conducted daily narcotic counts to verify accuracy on 4/30, 5/4, 5/5, 5/6, 5/7, 5/8 and 5/11 and weekly counts thereafter to ensure that there were no additional missing narcotic issues.
System changes to ensure compliance with the regulation:	Narcotic count procedures and medication rights for administering medications will be reviewed at all monthly nursing meetings for 6 months and nursing staff will be randomly questioned to ensure understanding of the policies. All medication error reports are reviewed weekly by the Director of Nursing and the Administrator to ensure the staff member making the error has had adequate education/retraining as needed, and all medication errors are reviewed at the quarterly QA meeting. The facility transitioned to the use of bingo cards (single med cards) instead of comingles (multi-med cards) on July 3, 2026 with the intent of minimizing the potential for errors. To date, there have been no medication errors under the new bingo card system. The Director of Nursing has purchased new training materials which will be used to enhance the already existing training that is given to new Med Aides.
Date corrected:	7/23/26
Who will monitor to ensure compliance:	Director of Nursing
DLP Use Only	R209 Plan of Correction accepted by Jo A Evans, RN on 7/22/2026

Survey Date: 6/22/26

Facility Name: Michaud Memorial Manor

Deficiency Tag:	R223
How the deficiency was corrected:	This incident was reported to the Director of Nursing and Administrator on 1/23/26, the morning after the event. The administrator confirmed through review of cameras that the time frame of the resident on the toilet was approximately 10 minutes. The DON assessed the resident and found no injuries. The staff member responsible was re-educated through disciplinary action on 1/26/26. A late-entry progress note and incident report was entered into the resident's medical record on 7/20/26.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	An audit will be conducted weekly for one month and monthly thereafter for 3 months to ensure that all reported incidents are properly documented in the resident's medical record.
System changes to ensure compliance with the regulation:	All facility nursing staff will be re-educated on the requirement to write an incident report and progress note for any incidents that occur at a nursing meeting on 7/23/26.
Date corrected:	7/23/26
Who will monitor to ensure compliance:	Director of Nursing
DLP Use Only	R223 Plan of Correction accepted by Jo A Evans, RN on 7/22/2026