pennsylvania
DEPARTMENT OF PUBLIC WELFARE

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: [illegible] 15 2013

Ms. Christina Yakich, Administrator
Canterbury Place
Ground Floor and Floors 2 – 6
310 Fisk Street
Pittsburgh, Pennsylvania 15201

Dear Ms. Yakich:

As a result of the Department of Public Welfare's (Department) licensing inspection on March 8, 2013, of the above personal care home, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed Violation Report were found.

All violations specified on the enclosed Violation Report must be corrected by the dates specified on the Violation Report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained. As soon as each violation is corrected, notify the Department's Regional Office of Human Services Licensing so that compliance can be verified.

Sincerely,

Jill Pezzino
Regional Licensing Administrator

Enclosure(s)

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

RECEIVED
JUN 25 2013
WEST REGION FIELD OFFICE
Human Services Licensing

PCH Name: CANTERBURY PLACE	**License Number:** 42949
Address: 310 FISK STREET, PITTSBURGH, PA 15201	**County:** Allegheny
Administrator: Tina Yakich	**Region:** WEST

Legal Entity Name: CANTERBURY PLACE

Legal Entity Address: 310 FISK STREET, PITTSBURGH, PA 15201

Certificate(s) of Occupancy

I-2
05/05/2010
City of Pittsburgh

Staffing Hours

Resident Support: 0	Total Daily Staff: 74	Waking Staff: 56
Type of Inspection: Partial	**BHA Docket Number:**	**Notice:** Unannounced

Reason(s) for Inspection(s)

Incident

On-Site Inspections Dates and Department Representatives On-Site

03/08/2013: Goedert, Caroline

Off-Site Inspection Dates and Inspectors, if Applicable

05/01/2013: Goedert, Caroline
03/15/2013: Goedert, Caroline

Other Details

Partial or Full Triggers:

Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 164

Number of Residents Served: 66

Secured Dementia Care Unit in Home: No

Area:

Secured Dementia Unit Capacity, if Applicable:

Number of Residents Served in Secured Dementia Care Unit, if applicable:

Number of Current Hospice Residents: 0

Number of Hospice Residents in past year: 8

Number of Residents who:

- **Receive Supplemental Security Income:** 0
- **Are 60 Years of Age or Older:** 66
- **Have Mental Illness:** 0
- **Have an Intellectual Disability:** 0
- **Have a Mobility Need:** 8
- **Have a Physical Disability:** 0

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JUL 13 2013
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Human Services Licensing

Violation Report: 42949-03/08/2013 Goedert, Caroline
PCH Name: CANTERBURY PLACE

1. REGULATION 55 Pa. Code 2600
2600.42 (b) – A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

On the morning of 3/4/13, resident #1 was found to have an altered mental status and was sent from the home to the emergency room for evaluation. Multiple skin tears and bruises were observed at admission to the hospital on 3/4/13 including multiple purple bruising left and right arm; healing skin tear right mid forearm; dark purple area left lower leg; multiple various shades purple bruising right lower extremity; 2 areas bruising left breast, yellow at 2 o'clock and purple at 7 o'clock; bridge nose scabbed abrasion with yellow bruising.

Resident #1 had a history of falls and unsafe transfer to wheelchair. The resident fell out of bed on 8/24/12 (two times). 10/24/12, 2/22/13, 2/24/13 and 3/2/13. The resident received a skin tear on 12/10/12 when transferring to the wheel chair unassisted by staff. The resident's support plan, dated 9/13/12, was not updated to address how the resident's needs related to falls and unsafe transfer to wheelchair will be addressed except on 2/24/13 after the resident fell and was treated in the ER for a fractured nose. The support plan was updated as follows. Adjustments made in room, bed against wall to prevent future falls/fracture nose/bruising and skin tears. The resident subsequently fell out of bed on 3/2/13 after his/her bed was moved. No other updates to support plan were made.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above the steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Resident diagnosis history does not reveal a history of falls. Resident DME from 2012 stated that one of the diagnoses was falls with gait disturbance. Resident support plan (9-13-12) (Exhibit A) detailed resident independent with transferring in/out of bed/chair and independent with mobility except for difficulty with distances for which a wheelchair was provided. There was not a significant change in functioning to warrant support plan change. Violation report detailed a fall on 3-2-13. Support plan addendum documentation status that resident did not fall on 3-2-13. Resident was found asleep with her body leaning over edge of bed without having moved from one surface to another or one level to another. Staff assisted resident to safely reposition in bed.

Violation report detailed skin tear occurred as a result of staff not assisting resident to wheelchair from bed. Support plan (9-13-12) and addendum documentation state that resident was independent with transfers and independent with mobility. Assist with transfers was not required but staff member was present when skin tear was obtained during transfer.

Plan of correction:
Plan of Correction: Canterbury Place Personal Care Home has implemented the following to address these findings:

- aDaily shift to shift report process for direct caregivers and medication aides/LPNs. Verbal report between shift staff includes all resident changes such as skin tears, falls, bruises or change of medical, functional or cognitive conditions. All reports of resident change are documented in the medical record at the time they are noted. All reports of resident change are evaluated by the on- coming shift staff member to determine immediate resident care needs and are reported to the Director of Resident Care and The resident support coordinator to determine if further investigation or additional resident care if required.
- Canterbury Place will implement a resident incident investigation process by 7-19-13_and implement a fall risk assessment process by 7-19-13_.
- Noted resident changes of all types and levels are documented in the RASP with a plan of care to prevent further and future decline in condition while supporting the care needs of the residents. RASP includes individualized measures for prevention and identification that are based on the resident change of status investigation findings and that direct the caregivers to a plan of care for the resident.
- Residents with unwitnessed falls or falls with injuries are monitored for the first 72 hours following the fall that includes documentation in the medical record of findings.
- Direct care staff and medication aides/LPNs will receive education related to the fall investigation process by July 19, 2013.
- Director of Resident Care or designee will audit compliance with shift to shift report, staff investigation of resident changes, medical record documentation, RASP updates, reports to Director of Resident Care and Resident Support Coordinator and fall risk assessments with documentation daily for a week, then weekly for a month, then bi-weekly for a month, then monthly for three months. Findings will be reported to the administrator and staff re-educated at the time of the finding.
- 9-20-13 As part of the fall risk process, residents at risk for falls will be assessed at least quarterly. 8-14-13 ggo

Repeat Violation: No	Date(s) of Previous Violations(s)			

Signature of Legal Entity Representative (Required on EVERY Page) [signature]

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CHRISTINA YAKZA

Date 7-13-13

DEPARTMENT USE ONLY – HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8-14-13 (date) The above plan of correction was approved by JYP (initials)	Plan of correction implementation status as of 8-14-13 ☐ Fully Implemented (date) ☒ Partially Implemented – Adequate Progress JYP ☐ Partially Implemented – Inadequate Progress ☐ Not Implemented

RECEIVED
JUL 18 2013
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Human Services Licensing

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JUL 1 8 2013
WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 42949-03/08/2013 Goedert, Caroline
PCH Name: CANTERBURY PLACE

1. REGULATION 55 Pa. Code 2600
2600.141(b)(1) – A resident shall have a medical evaluation at least annually.

2a. DESCRIPTION OF VIOLATION
Resident #1 had a history of gait disturbance and falls as indicated on the residents' Medical Evaluation dated 5/29/12. The residents' assessment and support plan, also finalized on 9/13/12, indicates the resident ambulates throughout the facility with a wheeled walker and the resident does not do well with distances.

On 10/8/2012 resident #q was seen at the physician office to evaluate contusion of hip. The physician noted that the resident ambulates fairly well with a walker. The physician consult sheet on record by the home instructed the resident to return in one month for follow-up evaluation. A follow-up evaluation was no done.

The resident fell on 10/24/12 and was found on the floor next to his/her bed. The residents' support plan was updated with a note that reads: as of January (2013) resident placed in w/c (wheelchair) for transport. She can self-propel throughout facility. Staff reported the resident was able to transfer himself/herself to the wheelchair, however, maybe not safely. Staff reported resident received a skin tear on 12/10/12 transferring to the wheelchair Staff reported observing a slow decline in the resident over the last 6 months. "We have provided a wheelchair for the resident for transport due to (their) decline with ambulation."

The home failed to obtain a new medical evaluation following significant change in the resident's ambulation needs.

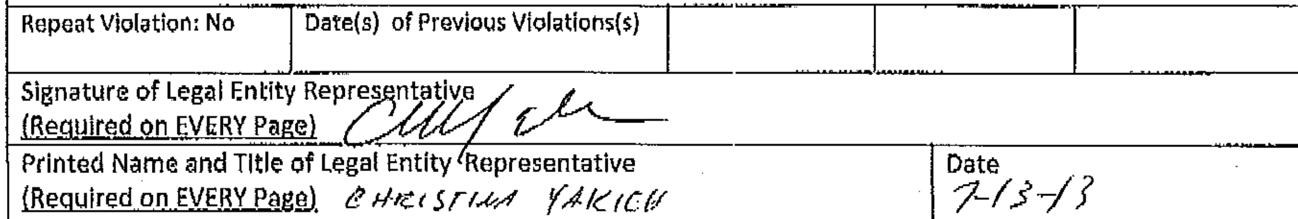
3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above the steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Resident did not demonstrate a change in ambulation or mobility per the documentation in the support plan (9-13-12). The resident demonstrated independence with mobility except for long distances for which she needed a wheelchair secondary to becoming tired but she self propelled in the wheelchair. The resident remained independent with ambulation using the assistive device of a wheeled walker and transfers were independent. The distance between resident room and dining room is 178 feet. Ambulation and Mobility status did not change, mobility device used for certain distances was addressed in the RASP. There was no significant change as evidenced by documentation in the RASP (Exhibit A). We noted no significant change in medical or functional status because the resident remained independent with functional status with the addition of assistive devices. This documentation does not support the need for a new DME.

Plan of correction: An appointment tracking form has been implemented for follow up physician appointments. Charge staff is responsible for monitoring appointments daily. Director of Resident care (DRC) or designee monitors appointment tracker for completion and follow up weekly based on 24 hour report from staff.
Canterbury Place Personal Care Home has implemented the following to address these findings:

- Daily shift to shift report process for direct caregivers and medication aides/LPNs. Verbal report between shift staff includes all resident changes such as skin tears, falls, bruises or change of medical, functional or cognitive conditions. All reports of resident change are documented in the medical record at the time they are noted. All reports of resident change are evaluated by the on- coming shift staff member to determine immediate resident care needs and are reported to the Director of Resident Care and The resident support coordinator to determine if further investigation or additional resident care if required.
- Noted resident changes of all types and levels are documented in the RASP with a plan of care to prevent further and future decline in condition while supporting the care needs of the residents. RASP includes individualized measures for prevention and identification that are based on the resident change of status investigation findings and that direct the caregivers to a plan of care for the resident.
- Direct care staff and medication aides/LPNs will receive education related to the communication process by July 19, 2013.
- Director of Resident Care or designee will audit compliance with shift to shift report, staff investigation of resident changes, medical record documentation, RASP updates, reports to Director of Resident Care and Resident Support Coordinator and fall risk assessments with documentation daily for a week, then weekly for a month, then bi-weekly for a month, then monthly for three months. Findings will be reported to the administrator and staff re-educated at the time of the finding.

Repeat Violation: No	Date(s) of Previous Violations(s)			



Signature of Legal Entity Representative
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CHRISTINA YAKICH	Date 7-13-13

DEPARTMENT USE ONLY – HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of (date) 8-14-13	Plan of correction implementation status as of 8-14-13
The above plan of correction was approved by (Initials)	☐ Fully Implemented(date) ☒ Partially Implemented – Adequate Progress ☐ Partially Implemented – Inadequate Progress ☐ Not Implemented

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Human Services Licensing

Violation Report: 42949-03/08/2013 Goedert, Caroline
PCH Name: CANTERBURY PLACE

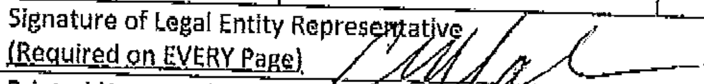
1. REGULATION 55 Pa. Code 2600
2600.142(a)- The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION
On 10/8/2012 resident #1 was seen at the physician office to evaluate contusion of hip. The physician noted that the resident ambulates fairly well with a walker. The physician consult sheet on record by the home instructed the resident to return in one month for follow-up evaluation. A follow-up evaluation was no done.

The resident fell out of bed on 2/24/13 and hit his/her head on a night stand. The resident was transported to the emergency room and diagnosed with a nasal fracture. Discharge instruction included the need to follow up the PCP in 2 days and with Otorhinolaryngologist (ear, nose and throat or ENT) in 2-3 days. No follow up occurred with the PCP or ENT

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above the steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.
An appointment tracking form has been implemented for follow up physician appointments. Charge staff are responsible for monitoring appointments daily. Director of Resident care (DRC) or designee monitors appointment tracker for completion and follow up weekly based on 24 hour report from staff. Charge staff report to DRC when information has not been returned from the physician or other appointment with the resident. DRC contacts office where appointment was completed to request a fax or scanned copy of the information related to the appointment for the medical record or to receive a verbal report from the appointment. Charge staff provide information to the resident and family related to the recommendation for a follow up appointment and discuss the benefits of the follow up appointment. Charge staff also follow up to request information regarding the appointment and document on the appointment tracker. This information will be documented as a progress note in the medical record..

Repeat Violation: No	Date(s) of Previous Violations(s)			

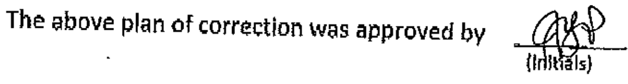
Signature of Legal Entity Representative
(Required on EVERY Page)


Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) CHRISTIAN YA RICA

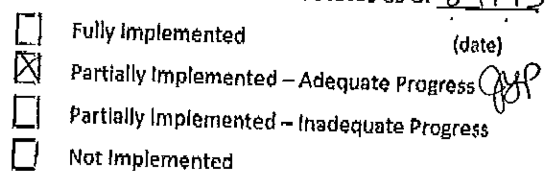
Date 7-13-13

DEPARTMENT USE ONLY – HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8-14-13 (date)

The above plan of correction was approved by  (Initials)

Plan of correction implementation status as of 8-14-13 (date)



- [ ] Fully Implemented
- [x] Partially Implemented – Adequate Progress
- [ ] Partially Implemented – Inadequate Progress
- [ ] Not Implemented

1. REGULATION 55 Pa. Code 2600

2600.143(b) - The following current emergency medical and health information shall be available at all times for each resident and shall accompany the resident when the resident needs emergency medical attention:

(1) The resident's name and birth date.
(2) The resident's social Security number.
(3) The residents' medical diagnosis.
(4) The resident's physician's name fan telephone number.
(5) Current medications, including the dosage and frequency.
(6) A list of allergies.
(7) Other relevant medical conditions.
(8) Insurance or third party payer and identification number.
(9) The power of attorney for health care or health care proxy, if applicable.
(10) The resident's designated person with current address and telephone number.
(11) Personal information and related instructions regarding advance directives do not resuscitate orders or organ donation, if applicable.

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2a. DESCRIPTION OF VIOLATION

The emergency medical information that accompanied resident #1 to the hospital on 3/4/13 did not include the resident's allergy to Penicillin or information related to the resident Power of Attorney for health care. The admission note to the Emergency Department indicated that the resident does have a power of attorney, and that the power of attorney that has a copy was bringing it to the hospital. On the day of the inspection, then Administrator obtained a copy of the Power of Attorney document from the hospital.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.) *Include steps to correct the violation described above the steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

Canterbury Personal Care Home is implementing a transfer checklist that will include all required information that must accompany the resident to all external appointments and hospital transfers. Transfer checklist will be completed by Charge staff at time of any transfer from the home. The transfer check list will include the pertinent medical information including medication, food and other allergies. Director of Resident Care or designee will audit completed checklist to ensure all required documents were sent with resident. The personal care home will assure that all residents will have the Power of Attorney documents in the medical record within one week from admission. This will be audited one week from admission for each admission by the Director of Resident Care and Resident Support Coordinator. Concerns will be documented in the medical record and the POA documents will be included in all external transfers from the facility.

Repeat Violation: No	Date(s) of Previous Violations(s)			

Signature of Legal Entity Representative (Required on EVERY Page) [signature]

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CHRISTINA YAKICH — Date 7-13-13

DEPARTMENT USE ONLY – HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8-14-13 (date)

The above plan of correction was approved by JSP (initials)

Plan of correction implementation status as of 8-14-13 (date)

- [ ] Fully implemented
- [x] Partially implemented – Adequate Progress JSP
- [ ] Partially implemented – Inadequate Progress
- [ ] Not implemented

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JUL 1 3 2013
WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 42949-03/08/2013 Goedert, Caroline
PCH Name: CANTERBURY PLACE

1. REGULATION 55 Pa. Code 2600

2600.227 (c) – The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

2a. DESCRIPTION OF VIOLATION

Resident #1 had a history of falls and unsafe transfer to wheelchair. The resident fell out of bed on 8/24/12 (two times), 10/24/12, 2/22/13, 2/24/13 and 3/2/13. The resident received a skin tear on 12/10/12 when transferring to the wheelchair unassisted by staff.

The resident's support plan. Dated 9/13/12, was not u8pdated to addr3ess how the resident's needs related to the falls and unsafe transfer to the wheelchair will be addressed except on 2/24/13 after the resident fell and was treated in the ER for a fractured nose. The support plan was updated as follows: adjustment made in room bed against wall to prevent further falls/fracture nose/bruising and skin tears. The resident subsequently fell out of bed on 3/2/13 after his/her bed was moved. No other updates to the support plan were made.

The resident's support plan was updated with a note that reads: as of January (2013) resident placed in w/c (wheel chair) for transport. The resident can self-propel throughout facility. Staff reported the resident was able to transfer himself/herself to the wheelchair: however, maybe no safely. Staff reported resident #1 received a skin tear on 12/10/12 transferring to the wheelchair. Staff reported observing a slow decline in the resident over the last 6 months. Staff stated in written statement "We have provided a wheelchair for the resident for transport due to her decline with ambulation." The resident's support plan was not updated to address assistance needed transferring to wheelchair.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above the steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Resident diagnosis history does not reveal a history of falls. Resident DME from 2012 stated that one of the diagnoses was falls with gait disturbance. Resident support plan (9-13-12) (Exhibit A) detailed resident independent with transferring in/out of bed/chair and independent with mobility except for difficulty with distances for which a wheelchair was provided. There was not a significant change in functioning to warrant support plan change. Violation report detailed a fall on 3-2-13. Support plan addendum documentation states that resident did not fall on 3-2-13. Resident was found asleep with her body leaning over edge of bed without having moved from one surface to another or one level to another. Staff assisted resident to safely reposition in bed.

Violation report detailed skin tear occurred as a result of staff not assisting resident to wheelchair from bed. Support plan (9-13-12) and addendum documentation state that resident was independent with transfers and independent with mobility. Assist with transfers was not required but staff member was present when skin tear was obtained during transfer.

Plan of Correction: Canterbury Place Personal Care Home has implemented the following to address these findings:

- aDaily shift to shift report process for direct caregivers and medication aides/LPNs. Verbal report between shift staff includes all resident changes such as skin tears, falls, bruises or change of medical, functional or cognitive conditions. All reports of resident change are documented in the medical record at the time they are noted. All reports of resident change are evaluated by the on- coming shift staff member to determine immediate resident care needs and are reported to the Director of Resident Care and The resident support coordinator to determine if further investigation or additional resident care if required.
- Canterbury Place will implement a resident incident investigation process by 7-19-13_and implement a fall risk assessment process by 7-19-13_.
- Noted resident changes of all types and levels are documented in the RASP with a plan of care to prevent further and future decline in condition while supporting the care needs of the residents. RASP includes individualized measures for prevention and identification that are based on the resident change of status investigation findings and that direct the caregivers to a plan of care for the resident.
- Residents with unwitnessed falls or falls with injuries are monitored for the first 72 hours following the fall that includes documentation in the medical record of findings.
- Direct care staff and medication aides/LPNs will receive education related to the fall investigation process by July 19, 2013.
- Director of Resident Care or designee will audit compliance with shift to shift report, staff investigation of resident changes, medical record documentation, RASP updates, reports to Director of Resident Care and Resident Support Coordinator and fall risk assessments with documentation daily for a week, then weekly for a month, then bi-weekly for a month, then monthly for three months. Findings will be reported to the administrator and staff re-educated at the time of the finding.

9-20-13 As part of the fall risk process, residents at risk for falls will be assessed at least quarterly. 8-14-13 [initials]

Repeat Violation: No	Date(s) of Previous Violations(s)	

Signature of Legal Entity Representative (Required on EVERY Page)	
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CHRISTINA YAKUBIK	Date 7-13-13

DEPARTMENT USE ONLY – HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8-14-13 (date) The above plan of correction was approved by [initials] (initials)	Plan of correction implementation status as of 8-14-13 (date) ☐ Fully Implemented ☒ Partially Implemented – Adequate Progress [initials] ☐ Partially Implemented – Inadequate Progress ☐ Not Implemented

RECEIVED
JUL 18 2013
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Human Services Licensing

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JUL 1 8 2013
WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 42949-03/08/2013 Goedert, Caroline
PCH Name: CANTERBURY PLACE

1. REGULATION 55 Pa. Code 2600

2600.2851(b) – The entries in a resident's record shall be permanent, legible, dated and signed by the staff person making the entry.

2a. DESCRIPTION OF VIOLATION

On 2/27/13, resident #1 had a physician's order for Tamiflu, 75 mg. The order had originally been written for a different dose, had been whited out, and had a handwritten change of the aforementioned dosage. In addition, there was no indication what the original order had been, who made the change, or the date the change was made to the order.

Resident #1's assessment-support plan indicated on the front page that is was completed on 1-13-12. However, the mobility section of the form had a hand-written entry that stated, "As of January (2013) resident placed in w/c for transport. (Resident) can self-propel throughout facility." There was no indication as to when the entry into the assessment-support plan was actually made. There were initials next to the entry, but it was not dated.

On the day of the inspection, Licensing Representative was provided with progress notes that were kept by staff person #1 at his/her desk in their office. The progress notes regarding resident #1 entitled "(Resident #1) Issues" had a chronological list of situations that had occurred regarding the resident and on the days the situations had occurred. However, the actual entries that were made were not dated and signed by the person who made the entries.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.) *Include steps to correct the violation described above the steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

Administrator and Resident Support Coordinator will provide staff education related to the home procedure for correcting medial record documentation errors which will be completed by July 17, 2013 for all caregiver and medication administration staff. Resident Support Coordinator will remove all correction fluid from the area immediately.

Personal care home staff will be educated that all resident events are to be documented in the medial record in the progress notes contemporaneously. Staff will be educated by the Director of Quality, Education and Compliance by July 17, 2013. All professional standard and home policies for medical record documentation will be reviewed in the education and followed during documentation. Director of Resident Care and Resident Support Coordinator will audit 10% of medical record documentation monthly for 6 months or until 90% compliance has been maintained.

Repeat Violation: No	Date(s) of Previous Violations(s)			

Signature of Legal Entity Representative (Required on EVERY Page) [signature]

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) CHRISTINA YAKICH — Date 7-15-13

DEPARTMENT USE ONLY – HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 8-14-13 (date)

The above plan of correction was approved by [initials] (initials)

Plan of correction implementation status as of 8-14-13 (date)

- ☐ Fully Implemented
- ☒ Partially Implemented – Adequate Progress [initials]
- ☐ Partially Implemented – Inadequate Progress
- ☐ Not Implemented