pennsylvania
DEPARTMENT OF PUBLIC WELFARE

MAY 1 2 2014

Ms. Suzanne Daughtrey, Administrator
NHS Pennsylvania
4391 Sturdbidge Drive
Harrisburg, Pennsylvania 17110

RE: NHS Lehigh Valley Center
515 Delaware Avenue
Bethlehem, Pennsylvania 18015
License #: 224010

Dear Ms. Daughtrey:

As a result of the Department of Public Welfare's licensing inspection on April 1, 2014, of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Your regular license for the period June 11, 2014 to June 11, 2015 was issued on April 16, 2014. Your regular license remains in good standing.

Sincerely,

Matthew J. Jones
Director

Enclosure
License Inspection Summary

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



| | |
|---|---|
| PCH Name: NHS LEHIGH VALLEY CENTER | License Number: 224010 |
| Address: 515 DELAWARE AVENUE, BETHLEHEM, PA 18015 | County: Lehigh |
| Administrator: Suzanna Daughtrey | Region: NORTHEAST |
| Legal Entity Name: NHS PENNSYLVANIA | |
| Legal Entity Address: 4391 STURBRIDGE DRIVE, HARRISBURG, PA 17110 | |

**Certificate(s) of Occupancy**

R4
04/23/2012
fountain hill Borough

**Staffing Hours**

Resident Support: NA | Total Daily Staff: 17 | Waking Staff: 13

Type of Inspection: Full | BHA Docket Number: | Notice: Unannounced

**Reason(s) for inspection(s)**

Renewal

**On-Site Inspections Dates and Department Representatives On-Site**

04/01/2014: Patton, Leslie

**Off-Site Inspection Dates and Inspectors, if Applicable**

**Other Details**

Partial or Full Triggers: | Random Indicators:

**Resident Demographic Data as of Inspection Dates**

Licensed Capacity: 16

Number of Residents Served: 15

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: 0

**Number of Residents who:**

Receive Supplemental Security Income: 13

Are 60 Years of Age or Older: 4

Have Mental Illness: 15

Have an Intellectual Disability: 0

Have a Mobility Need: 2

Have a Physical Disability: 1

Violation Report: 22401 - 04/01/2014 - Patton, Leslie
PCH Name: NHS LEHIGH VALLEY CENTER

1. REGULATION 55 Pa.Code §2600
2600.3(c) - The personal care home shall post the current license, a copy of the current licensing inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

2a. DESCRIPTION OF VIOLATION
The home's license was posted in the first floor office and not in a public and conspicuous location.

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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

This citation was corrected at the time of inspection on 4/1/14. The homes' license is now posted on the public bulletin board in the front lobby. This posting will be updated by the administrator when new licenses are sent to the home. The placement will remain in the lobby so that all residents and visitors can view our license. The administrator will review this monthly to ensure the license continues to be posted in the proper location.

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|

Signature of Legal Entity Representative (Required on EVERY Page) Michael J. Breslin

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Michael J. Breslin, COO

Date 4/18/14

**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of 4-30-14 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 4-30-14 (Date)

- [ ] Fully Implemented
- [X] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 22401 - 04/01/2014 - Patton, Leslie
PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**

2600.65(a) - Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

(1) Evacuation procedures.
(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
(5) The location and use of fire extinguishers.
(6) Smoke detectors and fire alarms.
(7) Telephone use and notification of emergency services.

**2a. DESCRIPTION OF VIOLATION**

Staff person A (hired 4/219/13) did not receive the training required to be completed on or before the first day of work.

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

On 4/4/13, staff member A was re-trained by the administrator in the following areas and a record of his training is attached:

(1) Evacuation procedures.
(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
(5) The location and use of fire extinguishers.
(6) Smoke detectors and fire alarms.
(7) Telephone use and notification of emergency services.

Moving forward, all staff members will be trained by the Administrator in these areas on the first day of work. Record of the trainings will be kept in the training documentation folder, on training logs, and reviewed monthly by the Administrator. Records of all trainings will also be kept on the Learning Management System, the electronic training record system utilized by NHS. Admor designee will audit all current employee records to insure current compliance 4/30/14

| Repeat Violation: Yes | Date(s) of Previous Violation(s): | 04/08/2013 | | |
|---|---|---|---|---|
| Signature of Legal Entity Representative (Required on EVERY Page) | Michael J. Breslin | | | |
| Printed Name and Title of Legal Entity Representative (Required on EVERY Page) | Michael J. Breslin, COO | | Date | 4/18/14 |

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Violation Report: 22401 - 04/01/2014 - Patton, Leslie
PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**

2600.65(b) - Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102).
(4) Reporting of reportable incidents and conditions.

**2a. DESCRIPTION OF VIOLATION**

Staff person A (hired 4/29/13) did not receive the training required to be completed before the first 40 hours of work.

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

On 4/4/13, staff member A was re-trained by the Administrator in the following areas, and a record of his training is attached:

(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101-10225.5102).
(4) Reporting of reportable incidents and conditions

Moving forward, all staff members will be trained by the Administrator in these areas within the first 40 hours of work. Record of trainings will be kept in the training documentation folder, on training logs, and reviewed monthly by the Administrator. Records of trainings will also be kept on the Learning Management System, the electronic training record system utilized by NHS.

Adm or designee will audit all current employee records to insure current compliance. CS 4-30-14

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|
| **Signature of Legal Entity Representative (Required on EVERY Page)** | Michael Breslin | | | |
| **Printed Name and Title of Legal Entity Representative (Required on EVERY Page)** | Michael J. Breslin, COO | **Date** 4/18/14 | | |

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- [x] Partially Implemented - Adequate Progress
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- [ ] Not Implemented

**Violation Report:** 22401 - 04/01/2014 - Patton, Leslie
**PCH Name:** NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**
2600.65(c) - Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

**2a. DESCRIPTION OF VIOLATION**
Staff person A (hired 4/29/13) did not receive training regarding his/her specific job functions as it relates to their position.

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

On 4/4/13, staff member A was given a retraining of the specific job functions related to his position by the Administrator, and a record of his training is attached. Moving forward, any ancillary staff persons will have a general orientation to their specific job functions as it relates to their position, prior to the start of working in that capacity. Records of trainings will be kept in the training documentation folder, on training logs, and reviewed monthly by the Administrator. Records of trainings will also be kept on the Learning Management System, the electronic training record system utilized by NHS.

All current employees receiving any job duties will have their record reviewed the the Adm/designee to insure current compliance. 4-30-14

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|

**Signature of Legal Entity Representative** (Required on EVERY Page) Michael Breslin

**Printed Name and Title of Legal Entity Representative** (Required on EVERY Page) Michael J. Breslin, COO **Date** 4/18/14

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The above plan of correction is approved as of 7-30-14 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 4-30-14 (Date)

- [ ] Fully Implemented
- [X] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

**Violation Report:** 22401 - 04/01/2014 - Patton, Leslie
**PCH Name:** NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**

2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
(3) Resident rights.
(4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101-10225.5102).
(5) Falls and accident prevention.
(6) New population groups that are being served at the home that were not previously served, if applicable.

**2a. DESCRIPTION OF VIOLATION**

Staff person B (hired 11/1/10) and staff person C (hired 11/1/10) did not receive training regarding fire safety during the most recent completed training year of 6/1/12- 5/30/13.

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

Staff persons A and C did not have a fire safety training run by a fire safety expert within the training year. Both staff persons completed a safety training run by a fire safety expert on 7/18/13. The record of training is attached. Going forward, the administrator will schedule fire safety training with a fire safety expert within the training year. The Administrator will include the fire safety training run by a fire safety expert on the training plan developed each year, and record attendance. Records of trainings will be kept in the training documentation folder, on training logs, and reviewed monthly by the Administrator. Records of trainings will also be kept on the Learning Management System, the electronic training record system utilized by NHS.

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|

**Signature of Legal Entity Representative** (Required on EVERY Page) Michael Breslin

**Printed Name and Title of Legal Entity Representative** (Required on EVERY Page) Michael J. Breslin, COO

**Date** 4/18/14

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

**Violation Report:** 22401 - 04/01/2014 - Patton, Leslie
**PCH Name:** NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**
2600.82(c) - Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

**2a. DESCRIPTION OF VIOLATION**
Resident #1 is an individual with vision deficits. The most recently completed RASP in the resident's record (dated 6/25/13) states, "The resident needs assistance in reading labels. All poisonous materials will be locked." The following items were found unlocked in the small cabinet underneath the sink in the dining room:
-"Spic and Span" brand disinfectant with a label that stated, " If in eyes...rinse eyes and call Poison Control Center or doctor for treatment advise."
- "Diversy" brand bathroom disinfectant cleaner with a label that stated, "Hazardous to humans and domestic animals. Call a Poison Control Center or doctor for treatment advice."

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

This citation was corrected at the time of inspection on 4/1/14. All poisons in the personal care home will be kept locked by staff. This was reviewed with staff in a staff meeting on 4/3/14. The sign in sheet and agenda for that meeting are attached. Moving forward, from 4/4/14, the Administrator will check the home daily for poisons and ensure that poisons are stored and locked. All staff will be held accountable to lock poisons appropriately. The poison checks will be recorded on the rounds check list used for resident checks (please see attached document), which will be reviewed by the Administrator.

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|
| **Signature of Legal Entity Representative (Required on EVERY Page)** | Michael J. Breslin | | | |
| **Printed Name and Title of Legal Entity Representative (Required on EVERY Page)** | Michael J. Breslin, COO | **Date** | 4/18/14 | |

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Violation Report: 22401 - 04/01/2014 - Patton, Leslie
PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**
2600.101(j)(2) - Each resident shall have the following in the bedroom: A chair for each resident that meets the resident's needs.

**2a. DESCRIPTION OF VIOLATION**
Single occupancy room #309 did not have a chair.

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

On 4/8/14, a chair was moved into room #309. Moving forward from 4/4/14, all staff will check for the required furniture in each resident room, including a chair. This will be done on rounds and while giving care in rooms, which occurs daily. This will be recorded on the rounds check list that is currently in use in the home. The rounds check list will be reviewed by the Administrator. This was discussed in staff meeting on 4/3/14. Sign in sheet and agenda are attached.

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|

**Signature of Legal Entity Representative** (Required on EVERY Page) Michael Breslin

**Printed Name and Title of Legal Entity Representative** (Required on EVERY Page) Michael J. Breslin COO

**Date** 4/18/14

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Violation Report: 22401 - 04/01/2014 - Patton, Leslie
PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**
2600.101(j)(5) - Each resident shall have the following in the bedroom: A bedside table or a shelf.

**2a. DESCRIPTION OF VIOLATION**
The bedside table located in single occupancy room #211, #305, and #309 was across the room and not located next to the bed.

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

Maintenance was contacted on 4/2/14 to build bedside tables that can be re-located easily by residents and attach onto the beds.

Until these tables can be completed and installed, beginning 4/4/14, staff will help residents arrange their rooms so that bedside tables currently in the rooms can be located close to the beds in rooms 211, 305 and 309. Beginning 4/4/14, Staff will check these rooms daily while doing rounds and providing care to ensure that tables are within reach of the bed. The furniture checks will be recorded on the rounds check list used for resident checks (Please see attached). The rounds check list will be reviewed by the Administrator. This was discussed in staff meeting on 4/3/14. Sign in sheet and agenda are attached.

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|

**Signature of Legal Entity Representative** (Required on EVERY Page) Michael J. Breslin

**Printed Name and Title of Legal Entity Representative** (Required on EVERY Page) Michael J. Breslin, COO

**Date** 4/18/14

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**Violation Report:** 22401 - 04/01/2014 - Patton, Leslie
**PCH Name:** NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**
2600.101(j)(7) - Each resident shall have the following in the bedroom: An operable lamp or other source of lighting that can be turned on at bedside.

**2a. DESCRIPTION OF VIOLATION**
There was no source of lighting next to the bed in single occupancy room #211, #305, and #309. The lamp in each room was located across the room.

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

Maintenance was contacted on 4/2/14 to buy clip on lamps that can be re-located easily by residents and clip onto the sides of the headboards on the beds. Until these lamps can be purchased and installed, beginning 4/4/14, staff will help residents arrange their rooms so that the lamps currently in the rooms are located close to the beds in rooms 211, 305 and 309. Starting 4/4/13, Staff will check these rooms daily while doing rounds and providing care to ensure that lamps are within reach of the bed. The furniture checks will be recorded on the rounds check list used for resident checks (Please see attached). The rounds check list will be reviewed by the Administrator. This was discussed in staff meeting on 4/3/14. Sign in sheet and agenda are attached.

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|
| **Signature of Legal Entity Representative (Required on EVERY Page)** | Michael Beal | | | |
| **Printed Name and Title of Legal Entity Representative (Required on EVERY Page)** | Michael J. Beale, COO | **Date** | 4/18/14 | |

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**Violation Report:** 22401 - 04/01/2014 - Patton, Leslie
**PCH Name:** NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**
2600.107(a) - The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

**2a. DESCRIPTION OF VIOLATION**
The home does not have a copy of the emergency preparedness plan for the municipality or town in which the home is located.

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

A copy of the municipality's emergency plan was obtained on 4/7/14, by the Administrator. Because of the length of this document, only the first page is provided for proof of compliance with this regulation. This document will be kept in the Administrator's office and updated copies will be obtained by the Administrator. The local municipal administrator was contacted and is willing to communicate with the Administrator on a yearly basis to ensure the Administrator is aware of any changes and/or updated information.

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|

**Signature of Legal Entity Representative** (Required on EVERY Page) Michael Breslin

**Printed Name and Title of Legal Entity Representative** (Required on EVERY Page) Michael J. Breslin, COO

**Date** 4/18/14

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Violation Report: 22401 - 04/01/2014 - Patton, Leslie
PCH Name: NHS LEHIGH VALLEY CENTER

1. REGULATION 55 Pa.Code §2600
2600.132(d) - Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert.

2a. DESCRIPTION OF VIOLATION
It was approximated that the evacuation time during the fire drill conducted on 6/28/13 was 3 minutes and documentation indicate the drill conducted on 1/31/14 took 2minutes and 35 second to evacuate. Both drills exceeded an evacuation time of 2minutes and 30 seconds due to residents being hesitant to evacuate to the designated fire safe area. The home does not have documentation from a fire safety expert granting additional evacuation time.

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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

On 4/2/14, the Administrator met with the residents who were reluctant to evacuate and stressed the importance of carrying out a timely evacuation due to the fact that both residents felt that too many drills were held at the PCH and did not want to evacuate "again". Both residents agreed to evacuate as quickly as possible in the future after the Administrator explained the importance of the drills. The conversation with the two residents is documented on the shift notes attached. Future drills will be timed by the Administrator (or designee), and Staff will help to evacuate residents within the time allowed by the fire safety expert. This was reviewed with staff during the staff meeting on 4/3/14 (Please see the attached sign in sheet and agenda).

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|

Signature of Legal Entity Representative (Required on EVERY Page) Michael Breslin

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Michael J. Breslin, COO

Date 4/18/14

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Violation Report: 22401 - 04/01/2014 - Patton, Leslie
PCH Name: NHS LEHIGH VALLEY CENTER

**1. REGULATION 55 Pa.Code §2600**
2600.132(f) - Alternate exit routes shall be used during fire drills.

**2a. DESCRIPTION OF VIOLATION**
The home's fire drill records indicate the home did not alternate exit routes during the drills conducted on 6/28/13, 7/2/13 and 8/28/13. The home used exit #1, 3, 4, 6, and 8 during all three fire drills.

**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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

Beginning 4/2/14, alternate exits will be utilized during fire drills to ensure that all residents know the alternate exits located within the home. Also beginning 4/2/14, the Administrator will make sure to "block" (pretending that an exit is inaccessible due to fire) an exit for practice so that residents will be sure to use alternating exits. The Administrator will also track the exits used on the department approved forms. This was reviewed with staff in the meeting on 4/3/14 (Please see attached sign in sheet and agenda). The next drill will be conducted on 4/18/14. This drill will use alternating exits.

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|

Signature of Legal Entity Representative (Required on EVERY Page) Michael J. Breslin

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Michael J. Breslin, COO

Date 4/18/14

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Violation Report: 22401 - 04/01/2014 - Patton, Leslie
PCH Name: NHS LEHIGH VALLEY CENTER

1. REGULATION 55 Pa.Code §2600
2600.141(a)(2) - The medical evaluation must include the following: (1) through (10)

2a. DESCRIPTION OF VIOLATION
The medical evaluation documentation completed for resident #2 (dated 6/20/13) does not indicate mediations prescribed to the resident. The medical evaluation states, "See MAR," but no MAR (medication administration record) was attached.

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 and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

The medical evaluation for resident #2 is attached, along with the medication list for that resident. Beginning on 4/2/14, the administrator will check all new or updated medical evaluations for listed attachments and ensure that the attachments are present.

QDM or designee will audit all existing ~~for~~ resident records to insure current compliance by 4-30-14

| Repeat Violation: No | Date(s) of Previous Violation(s): | | | |
|---|---|---|---|---|

Signature of Legal Entity Representative (Required on EVERY Page) Michael J. Breslin

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Michael J. Breslin COO

Date 4/18/14

**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of 4-30-14 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 4-30-14 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented