pennsylvania
DEPARTMENT OF HUMAN SERVICES

OCT 25 2017

Ms. Anna Munoz
Assistant Secretary
Emeritus Corporation
6737 West Washington Street, Suite 230
Milwaukee, Wisconsin 53214

RE: Brookdale Harrisburg
3560 North Progress Avenue
Harrisburg, Pennsylvania 17110
Certificate #: 316110

Dear Ms. Munoz:

As a result of the Department of Human Services' Adult Residential Licensing's annual licensing inspection on May 31, 2017, June 1, 2017, August 16, 2017, and September 26, 2017 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.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

Bureau of Human Services Licensing
625 Forster Street, Room 631 | Harrisburg, PA 17120 | 717.783.3670 | F 717.783.5662 | www.dhs.state.pa.us

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

PCH Name: BROOKDALE HARRISBURG	**License Number:** 31611
Address: 3560 NORTH PROGRESS AVENUE, HARRISBURG, PA 17110	**County:** Dauphin
Administrator: Samantha Sipe	**Region:** CENTRAL

Legal Entity Name: EMERITUS CORPORATION

Legal Entity Address: 3131 ELLIOTT AVENUE STE. 500, SEATTLE, WA 98121

Certificate(s) of Occupancy

C-2 LP
11/20/1997
Labor & Industry

Staffing Hours

Resident Support: 0	**Total Daily Staff:** 82	**Waking Staff:** 62
Type of Inspection: Full	**BHA Docket Number:**	**Notice:** Unannounced

Reason(s) for Inspection(s)

Renewal, Complaint

On-Site Inspections Dates and Department Representatives On-Site

05/31/2017: McCloskey, Jason; Comstock, Kelly
06/01/2017: McCloskey, Jason; Comstock, Kelly

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: 66

Number of Residents Served: 55

Secured Dementia Care Unit in Home: Yes

Area: Clare Bridge

Secured Dementia Unit Capacity, if Applicable: 24

Number of Residents Served in Secured Dementia Care Unit, if applicable: 24

Number of Current Hospice Residents: 3

Number of Hospice Residents in past year: 9

Number of Residents who:

- **Receive Supplemental Security Income:** 0
- **Are 60 Years of Age or Older:** 55
- **Have Mental Illness:** 0
- **Have an Intellectual Disability:** 0
- **Have a Mobility Need:** 27
- **Have a Physical Disability:** 0

Violation Report: 31611 - 05/31/2017 - McCloskey, Jason
PCH Name: BROOKDALE HARRISBURG

1. REGULATION 55 Pa.Code §2600
2600.17 - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

2a. DESCRIPTION OF VIOLATION
On 5-31-17 at 9:30am, two binders were sitting unattended and accessible on a table in the dining room. The binders, labeled "Personal Care Diets" and "Clare Bridge Diets" contained the names of residents in the home as well as special dietary orders and restrictions including "carbohydrate controlled" for Resident 1 and "no added sodium" for Resident 2.

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.

SEE ATTACHED

Page 2A

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Samantha Sipe, Executive Director

Date 7/6/2017

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

The above plan of correction is approved as of 7/10/17 (Date)

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

Plan of correction implementation status as of 9/27/17 (Date)

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

Brookdale Harrisburg

Plan of Correction

The following is the Plan of Correction for Brookdale Harrisburg regarding the Statement of Deficiency dated June 29, 2017 for the Renewal Inspection on May 31, 2017 and June 1, 2017. This Plan of Correction is not to be as a Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Regulation 2600.17

Immediately the Dining Services Coordinator removed the Clare Bridge and the Personal Care dietary binders and relocated them to the kitchen pantry. The Executive Director (ED) completed an in-service training on June 1, 2017 with the Dining Services Coordinator to review the community policy on confidentiality of resident records. The ED will conduct random weekly audits for two months to monitor for compliance and determine if further action is required. The ED will direct additional actions based on findings.

Evidence – Training Attendance Form

Completion Date – **June 1,.2017 and ongoing**

Violation Report: 31611 - 05/31/2017 - McCloskey, Jason
PCH Name: BROOKDALE HARRISBURG

1. REGULATION 55 Pa.Code §2600
2600.63(a) - At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

2a. DESCRIPTION OF VIOLATION
On 5-20-17, from 11pm - 7am, more than 50 residents were present in the home, however, only 1 staff person with current first aid and CPR was present in the home.

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.

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Page 3A of 7

Regulation 2600.63(a)

Immediately, Resident Care Coordinator performed an audit of all employees CPR certification to identify expirations.

Ongoing, Resident Care Coordinator will audit CPR binder monthly to be sure CPR certifications are current. Resident Care Coordinator will review staffing schedules to assure each shift has at least one associate is CPR certified per every 50 residents. ED completed an in-service on June 2, 2017 with the Resident Care Coordinator to review the community policy on CPR training requirements and the importance of continuing to monitor schedules to assure all shifts are staffed appropriately. Executive Director spoke with representative at McBride at Nation's Best CPR and scheduled a CPR/First Aid/AED course on July 13, 2017 that will be held at Brookdale Harrisburg. The ED will review the findings for compliance and determine if further action is required for the next 3 months. The ED will direct additional actions based on findings.

Evidence – Training Attendance Form

Completion Date – June 2, 2017 and ongoing

* **Regulation 2600.63(a)**

Ongoing, Resident Care Coordinator and Executive Director will audit CPR binder monthly to verify CPR certifications are current. Executive Director retrained the appropriate staff regarding the community policy on CPR training on August 25, 2017. Resident Care Coordinator will review staffing schedules to verify each shift has at least one associate who is CPR certified per every 50 residents. CPR classes were held on July 13, 2017 and August 14, 2017 by Nation's Best CPR. As of August 14, 2017 all overnight associates are CPR certified. Executive Director has spoken with Nation's Best CPR and scheduled CPR/First Aid/AED courses on October 10th, 24th, and November 21st that will be held at Brookdale Harrisburg. By the end of November 2017 our goal is to have 100% of our associates CPR/First Aid certified. Executive Director will randomly review the schedule to verify each shift has the appropriate amount of CPR certified associates for the resident's being served for 2 months. The Executive Director will direct additional actions based on findings.

Evidence – Updated CPR certificates on file, retraining attendance

Completion Date – July 13, 2017 and ongoing BAS 9/27/17

Violation Report: 31611 - 05/31/2017 - McCloskey, Jason
PCH Name: BROOKDALE HARRISBURG

1. REGULATION 55 Pa.Code §2600
2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION
Residents 3 and 1 receive blood sugar testing twice a day. A detailed comparison of blood sugar readings stored on the resdients' glucometers was made with the readings recorded on the medication administration records (MARs). Readings recorded on Resident 3's MARs were stored on Resident 1's meter on 5-29-17 and on 5-19-17 at 8:00pm. Staff person A confirmed that s/he had used Resident 1's meter to test Resident 3's blood sugar.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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(Required on EVERY Page) Samantha Sipe, Executive Director — Date 7/6/2017

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- [ ] Not Implemented

Regulation 2600.85(a)

Immediately, the Resident Care Coordinator discarded Resident #1 's glucometer and replaced it with a new one. A back-up glucometer was also purchased to be used as a replacement in the event one malfunctions. The appropriate staff were re-trained on the community policy regarding glucometers by the Resident Care Coordinator on June 2, 2017. A weekly audit tool has been developed to compare the medication administration documentation to the meter and will be used for 2 months by the Resident Care Coordinator or designee. The Executive Director or designee will review audit findings for 2 months to determine compliance and to verify if any further action is warranted.

Evidence: Re-training attendance sheets, Audit tool

To be completed: June 2, 2017 and ongoing

Resident #1's physician will be notified of the shared glucometer use by the home, and the home will follow all resulting recommendations made by the physician (i.e. testing for blood borne pathogen). Documentation of the notification to the physician, the recommendations of the physician, and the home's follow-up based on the recommendations shall be maintained by the home for Department review. The notification to the physician shall be completed within seven days from the receipt of this plan. BAS 7/10/17

The home shall review and amend the home's policies regarding Glucometer usage. A copy of the updated policy will be provided to and reviewed with all medication administration staff. This shall be completed within 30 days from the receipt of this plan. BAS 7/10/17

Violation Report: 31611 - 05/31/2017 - McCloskey, Jason
PCH Name: BROOKDALE HARRISBURG

1. REGULATION 55 Pa.Code §2600
2600.162(c) - Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

2a. DESCRIPTION OF VIOLATION
The only menu posted in the home was for Sunday 5-28-17 through Saturday 6-3-17.

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.

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Page 5A

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- ☐ Not Implemented

Regulation 2600.162(c)

Immediately, Dining Services Coordinator posted the correct two week menu. ED completed an in-service with the Dining Services Coordinator on the community policy regarding posting the correct two week menu on June 1, 2017. Executive Director will randomly audit the menus for two months to monitor for compliance and determine if further action is required. The ED will direct additional actions based on findings.

Evidence – Training Attendance Form

Completion Date – June 1, 2017 and ongoing

Violation Report: 31611 - 05/31/2017 - McCloskey, Jason
PCH Name: BROOKDALE HARRISBURG

1. REGULATION 55 Pa.Code §2600
2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION
On 4/28/17, the home obtained a physician's order for wound care for Resident 7 that directed the home to "Check both lower legs every shift. Cleanse open areas with normal saline, cover with non-adherent dressing and wrap leg with Kerlix." As evidenced by interviews with staff of the home, the staff also wrapped the resident's legs in disposable underpads with a plastic backing. The use of these pads as a dressing for the wound care was not in accordance with the physician's order.

Resident 4 is prescribed Mucinex Tablet Extended Release 12 hr 600 MG 1 tablet every 12 hours as needed for cough. The medication on-hand was Mucinex Tablet Extended Release 12 hr 600 MG Guaifenesin + 30 MG Dextromethorphan. This medication was administered to Resident 4 on 5-12-17 at 8:31pm and on 5-22-17 at 7:36pm.

Resident 5 was prescribed fasting blood sugar checks 3 times weekly on 12-22-15. The home has not performed these checks for the resident since June of 2016.

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.

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Page 6A

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Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Samantha Sipe, Executive Director — **Date** 7/6/2017

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Plan of correction implementation status as of 9/27/17 (Date)

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- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Regulation 2600.187 (d)

Immediately, upon noticing that Resident 4's medication did not match the physician's orders, the prescriber was notified and the order was clarified. Immediately, the Mucinex Tablet Extended Release 12 hr 600 mg Gualfenesin +30mg Dextromethorphan was discarded. The family, who supplies the resident medication, was instructed to purchase the medication according to the physician order. Medication technicians will carefully compare that the medication brought in by the family matches identically to the orders the physician prescribes.

Immediately, the blood sugar was taken on resident #5 and was determined to be in normal range. The order for blood sugars was immediately corrected in Point Click Care to match the physician's orders. The physician was notified and the order for blood sugars was decreased to twice weekly.

On June 2, 2017 the medication technicians and LPN's were re-trained by the Resident Care Coordinator on the community policy regarding following the directions of the prescriber for any medications, wound care or treatment.

Resident Care Coordinator or designee will audit any new orders to assure they are entered correctly in Point Click Care and are given as directed. Executive Director will review audit results randomly for 2 months to monitor compliance and determine if further action is required.

Evidence – Training Attendance Form

Completion Date – June 2, 2017

* **Regulation 2600.187(a)**

Immediately, Resident Care Coordinator contacted Celtic Home Health to provide the community with the documentation completed following wound care treatment on July 13, 2017 and July 18, 2017, which they provided.

Ongoing, Resident Care Coordinator or designee will audit weekly medication treatment records to verify treatments are documented according to community policy. Health and Wellness Director or designee will review all wound care documentation being provided by outside agencies in the clinical file as evidence of the service being completed. The outside agency providing wound care will report to the Health and Wellness Director or designee weekly the status of services provided.

Resident Care Coordinator and Health and Wellness Director were in-serviced on the importance of documentation and follow up on the medication administration records by the Executive Director on August 16, 2017.

The Health and Wellness Director will review clinical documentation weekly to verify if any further action is warranted.

Evidence - Attached documentation from Celtic Home Health, Re-training attendance sheets

Completion Date – August 16, 2017 and Ongoing

BHS

Violation Report: 31611 - 05/31/2017 - McCloskey, Jason
PCH Name: BROOKDALE HARRISBURG

1. REGULATION 55 Pa.Code §2600
2600.227(g) - Individuals who participate in the development of the support plan shall sign and date the support plan.

2a. DESCRIPTION OF VIOLATION
Resident 6 participated in the development of their support plans dated 3-15-17 and 4-13-17. The resident did not sign the support plans.

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.

SEE ATTACHED
Page 7A

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Samantha Sipe, Executive Director — Date 7/6/2017

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

Plan of correction implementation status as of 9/27/17 (Date)

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- [ ] Not Implemented

Regulation 2600.227 (g)

Immediately, the support plan was reviewed with the resident and signed.

ED completed an in-service with the Resident Care Coordinator and Licensed Practical Nurse on June 2, 2017 to review the community policy on completing a support plan which is to include resident participation and signature. The Resident Care Coordinator or designee will audit the support plans monthly to assure signatures are present. The Health and Wellness Director or designee will review audit results to verify if further action is warranted.

Evidence – Training Attendance Form, copy of signed support plan

Completion Date – June 2, 2017

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

PCH Name: BROOKDALE HARRISBURG

License Number: 31611

Address: 3560 NORTH PROGRESS AVENUE, HARRISBURG, PA 17110

County: Dauphin

Administrator: Samantha Sipe

Region: CENTRAL

Legal Entity Name: EMERITUS CORPORATION

Legal Entity Address: 3131 ELLIOTT AVENUE STE. 500, SEATTLE, WA 98121

Certificate(s) of Occupancy

C-2 LP
11/20/1997
Labor & Industry

Staffing Hours

Resident Support: 0 | **Total Daily Staff:** 82 | **Waking Staff:** 62

Type of Inspection: Interim - POC | **BHA Docket Number:** | **Notice:** Unannounced

Reason(s) for Inspection(s)

Interim

On-Site Inspections Dates and Department Representatives On-Site

08/16/2017: Swanger, Brett;

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: 66

Number of Residents Served: 53

Secured Dementia Care Unit in Home: Yes

Area: Clare Bridge

Secured Dementia Unit Capacity, If Applicable: 24

Number of Residents Served in Secured Dementia Care Unit, If applicable: 24

Number of Current Hospice Residents: 4

Number of Hospice Residents in past year: 10

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 53

Have Mental Illness: 0

Have an Intellectual Disability: 0

Have a Mobility Need: 29

Have a Physical Disability: 2

Violation Report: 31611 - 08/16/2017 - Swanger, Brett
PCH Name: BROOKDALE HARRISBURG

1. REGULATION 55 Pa.Code §2600
2600.63(a) - At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

2a. DESCRIPTION OF VIOLATION
On 8/1/17, during the period of 11pm to 7am, more than 50 residents were present in the home. During this period, only 1 staff person who was certified in first aid, obstructed airway techniques and CPR were present in the home.

On 8/2/17, 8/3/17, and 8/5/17, during the period of 11pm to 7am, more than 50 residents were present in the home. During this period no staff persons who were certified in first aid, obstructed airway techniques and CPR were present in the home.

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.

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Samantha Sipe, Executive Director **Date** 8/23/2017

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Plan of correction implementation status as of 9/27/17 (Date)

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Brookdale Harrisburg

Plan of Correction

The following is the Plan of Correction for Brookdale Harrisburg regarding the Statement of Deficiency dated August 17, 2017 for the Follow Up Inspection on August 16, 2017. This Plan of Correction is not to be as a Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Regulation 2600.63(a)

Ongoing, Resident Care Coordinator and Executive Director will audit CPR binder monthly to verify CPR certifications are current. Executive Director retrained the appropriate staff regarding the community policy on CPR training on August 25, 2017. Resident Care Coordinator will review staffing schedules to verify each shift has at least one associate who is CPR certified per every 50 residents. CPR classes were held on July 13, 2017 and August 14, 2017 by Nation's Best CPR. As of August 14, 2017 all overnight associates are CPR certified. Executive Director has spoken with Nation's Best CPR and scheduled CPR/First Aid/AED courses on October 10th, 24th, and November 21st that will be held at Brookdale Harrisburg. By the end of November 2017 our goal is to have 100% of our associates CPR/First Aid certified. Executive Director will randomly review the schedule to verify each shift has the appropriate amount of CPR certified associates for the resident's being served for 2 months. The Executive Director will direct additional actions based on findings.

Evidence – Updated CPR certificates on file, retraining attendance

Completion Date – July 13, 2017 and ongoing

Violation Report: 31611 - 08/16/2017 - Swanger, Brett
PCH Name: BROOKDALE HARRISBURG

1. REGULATION 55 Pa.Code §2600
2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:
(1) Resident's name.
(2) Drug allergies.
(3) Name of medication.
(4) Strength.
(5) Dosage form.
(6) Dose.
(7) Route of administration.
(8) Frequency of administration.
(9) Administration times.
(10) Duration of therapy, if applicable.
(11) Special precautions, if applicable.
(12) Diagnosis or purpose for the medication, including pro re nata (PRN).
(13) Date and time of medication administration.
(14) Name and initials of the staff person administering the medication.

2a. DESCRIPTION OF VIOLATION
The medication administration record for Resident #1 does not document the wound care that was provided on 7/13/17 and 7/18/17.

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.

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Regulation 2600.187(a)

Immediately, Resident Care Coordinator contacted Celtic Home Health to provide the community with the documentation completed following wound care treatment on July 13, 2017 and July 18, 2017, which they provided.

Ongoing, Resident Care Coordinator or designee will audit weekly medication treatment records to verify treatments are documented according to community policy. Health and Wellness Director or designee will review all wound care documentation being provided by outside

agencies in the clinical file as evidence of the service being completed. The outside agency providing wound care will report to the Health and Wellness Director or designee weekly the status of services provided.

Resident Care Coordinator and Health and Wellness Director were in-serviced on the importance of documentation and follow up on the medication administration records by the Executive Director on August 16, 2017.

The Health and Wellness Director will review clinical documentation weekly to verify if any further action is warranted.

Evidence - Attached documentation from Celtic Home Health, Re-training attendance sheets

Completion Date – August 16, 2017 and Ongoing

Violation Report: 31611 - 08/16/2017 - Swanger, Brett
PCH Name: BROOKDALE HARRISBURG

1. REGULATION 55 Pa.Code §2600
2600.224(a) - A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

2a. DESCRIPTION OF VIOLATION
The pre-admission screening form for Resident #1, completed [redacted]17, did not incude a determination that the home can meet the resident's service needs.

The pre-admission screening form for Resident #2, completed [redacted]17, did not incude a determination that the home can meet the resident's service needs.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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- ☐ Not Implemented

Regulation 2600.224(a)

Immediately, Resident Care Coordinator updated the pre-admission screening for Resident #1 and Resident #2 to document that the resident's needs could be met in the personal care home as per physician order. Resident Care Coordinator and Executive Director completed an audit on all health care charts to verify all pre-admission screening forms were completed in their entirety with the appropriate boxes being checked. The Executive Director re-trained the Health and Wellness Director and Resident Care Coordinator on the community policy regarding completion of the prescreen document on August 25, 2017.

Ongoing, Resident Care Coordinator as well as the Health and Wellness Director or designee will review and initial the prescreen document and DME as a process of completion.

Executive Director will audit prescreens to verify they are completed in their entirety for two months to verify if further action is warranted.

Evidence – Corrected prescreen on file, training attendance sheet

Completion Date – August 16, 2017 and ongoing