



pennsylvania
DEPARTMENT OF HUMAN SERVICES

APR 03 2019

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

RE: Brookdale Latrobe
500 Bowers Drive
Latrobe, Pennsylvania 15650
Certificate #: 428530

Dear Ms. Munoz:

As a result of the Department's Bureau of Human Services Licensing annual inspection on December 20, 2018, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with Choose an item. 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
Violation Report

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

PCH Name: BROOKDALE LATROBE		License Number: 42853
Address: 500 BROWERS DRIVE, LATROBE, PA 15650		County: Westmoreland
Administrator: Roni Angus		Region: WEST
Legal Entity Name: EMERITUS CORPORATION		
Legal Entity Address: 6737 W WASHINGTON ST SUITE 2300, MILWAUKEE, WI 53214		
Certificate(s) of Occupancy C-2 LP 06/28/2001 Dept L&I		
Staffing Hours		
Resident Support: 0	Total Daily Staff: 121	Waking Staff: 91
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Renewal		
On-Site Inspections Dates and Department Representatives On-Site 12/20/2018: Duncan, Amy; Roser, Ashley; McConnell, Deb		
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: 150 ✓ Number of Residents Served: 80 ✓ Secured Dementia Care Unit in Home: Yes Area: Clare Bridge Secured Dementia Unit Capacity, if Applicable: 40 ✓ Number of Residents Served in Secured Dementia Care Unit, if applicable: 35 ✓ Number of Current Hospice Residents: 8 ✓ Number of Hospice Residents in past year: 30 ✓		Number of Residents who: Receive Supplemental Security Income: 0 ✓ Are 60 Years of Age or Older: 80 ✓ Have Mental Illness: 1 ✓ Have an Intellectual Disability: 0 ✓ Have a Mobility Need: 41 ✓ Have a Physical Disability: 0 ✓

Violation Report: 42853 - 12/20/2018 - Duncan, Amy
 PCH Name: BROOKDALE LATROBE

1. REGULATION 55 Pa.Code §2600
 2600.18 - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

2a. DESCRIPTION OF VIOLATION

The Care Facility Carbon Monoxide Alarms Standards Act, enacted June 23, 2016, requires a carbon monoxide alarm to be installed in close proximity of, but not less than 15 feet from, any fossil fuel device or appliance. Carbon monoxide detectors were present in the following areas where fossil-fuel devices are present; however, were too close to the devices:
 * Within 3 feet of the gas furnace and the 2 gas hot water tanks in the Abbey hallway furnace room
 * Within 3 feet of the gas furnace in the secured dementia care unit furnace room
 * Within 12 feet of the gas furnace in the main laundry room
 * Within 5 feet of the 4 gas hot water tanks in the main laundry 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.

Regulation 2500.18

Immediately, the Maintenance Director relocated and hard-wired the Carbon Monoxide Detectors to be no less than 15 feet from the fossil fuel burning devices of the gas furnace and 2 gas hot water tanks in the Abbey Hallway furnace room, at the gas furnace in the SDU furnace room, in the main laundry room gas furnace and near the 4 gas hot water tanks in the main laundry room.

February 21, 2019- The Executive Director retrained the Maintenance Director and Maintenance Assistant on the community policy regarding Carbon Monoxide Detectors. The Maintenance Director or designee will periodically review the functionality of these devices to verify they are in working condition. The Executive Director will determine if any further action is warranted.

Evidence: in-service attendance sheet, picture of the carbon monoxide detectors, Carbon Monoxide Specifics for installation

Completion Date: February 21, 2019

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) *Roni Angus*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Roni Angus, ED* Date *2/28/2018*

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

The above plan of correction is approved as of <u>3/1/19</u> (Date) The above plan of correction was approved by <u><i>LA</i></u> (Initials)	Plan of correction implementation status as of <u>3/1/19</u> (Date) <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <i>LA</i> <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented
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Violation Report: 42853 - 12/20/2018 - Duncan, Amy

PCH Name: BROOKDALE LATROBE

1. REGULATION 55 Pa.Code §2600

2600.81(b) - Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION

The enabler bar on the bed in bedroom #12A is not secure to the bed.

The enabler bar on the bed in bedroom #28 is not secure to the bed.

The enabler bar on the bed in bedroom #40B is not secure 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.

Regulation 2600.81 (b)

Immediately, the enabler bars were secured to the beds temporarily until a change to secured HALO SAFETY DEVICES could be discussed with each family, procured, residents trained and then secured next to each bed. The enabler bars in rooms' #12A, #40B have been removed and room #28 are being replaced with HALO SAFETY RING devices that are secured to the floor for greater stability and safety.

February 21, 2019-Clinical Department Managers were in-serviced by the Executive Director and Health/Wellness Director on the community policy regarding the use of secured devices for bed mobility on resident beds.

February 21, 2019- District Director of Clinical Services re-trained the Health and Wellness Director on the community policy regarding bedside mobility and HALO Devices.

An audit was done in all resident rooms to assess for resident use of any non-approved enabler bar devices on December 28, 2018. None were found. New residents and families that move-ins will be educated as to what bedside devices are approved on admission.

The Health and Wellness Director reviewed audit results and determined no further action was indicated. Periodic room checks will be completed by the clinical leaders for the next 2 months to determine if further action is required. The Health and Wellness Director will direct additional actions based on audit findings.

Evidence: In-service attendance sheet, attached fact sheet on Bedside Safety Devices

Completion date: March 15, 2019

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Violation Report: 42853 - 12/20/2018 - Duncan, Amy
 PCH Name: BROOKDALE LATROBE

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

2a. DESCRIPTION OF VIOLATION

There were no paper towels, mechanical blower, individual cloth towels or other sanitary means of hand drying in the following areas:
 * The shared bathroom of bedroom #12
 * The shared bathroom of bedroom #40
 * The common bathroom by the sitting room in the home's secured dementia care unit

At approximately 11:25 am, there was an unlabeled wash cloth hanging on the grab bar in the shared shower of bedroom #12.

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.

Regulation 2600.85 (a)

Immediately, the Housekeeper replaced the paper towels in the dispenser in the common area bathroom in SDU.

Immediately in room # 12 and #40, Maintenance Director added additional towel racks and residents names were labeled and replaced with fresh towels.

Immediately, the direct care staff replaced the towels to the shared bathroom in bedroom #12 and bedroom #40.

February 22, 2019- Appropriate associates were in-serviced by the Health and Wellness Director on the community policy regarding sanitary conditions relating to availability of towels in bathrooms.

The Health and Wellness Coordinator or designee will audit random bathrooms weekly to verify availability of hand drying towels. The Health and Wellness Director will review audit results for the one month to monitor for compliance and determine if further action is required.

Evidence: In-service attendance sheet, pictures of the towel racks

Completion date: February 28, 2019

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) *Roni Angus*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Roni Angus, ED</i>	Date <i>2/28/2019</i>
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Violation Report: 42853 - 12/20/2018 - Duncan, Amy
 PCH Name: BROOKDALE LATROBE

1. REGULATION 55 Pa.Code §2600
 2600.102(d)(1) - Toilet and bath areas must have grab bars, hand rails or assist bars.

2a. DESCRIPTION OF VIOLATION

No grab bar, hand rails or assist bars are present at the urinal in the men's common bathroom in the front lobby.

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.

Regulation 2600.102(d)(1)

Immediately, the Maintenance Director installed a grab bar in close proximity to the men's urinal in the bathroom off the lobby.

February 22, 2019- The Maintenance Director and appropriate staff were retrained by the Executive Director on the community policy regarding toilet and bath areas requiring assist bars.

February 22, 2019- An audit was completed by the Maintenance Director on all bathrooms and bath areas to verify that assist bars are in place.

The Executive Director reviewed audit results for compliance and determined no further action was required.

Evidence: attendance log, picture of new grab bar

Completion date: February 25, 2019

Repeat Violation: No	Date(s) of Previous Violation(s):			
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Signature of Legal Entity Representative (Required on EVERY Page) *Roni Angus*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Roni Angus, ED</i>	Date <i>2/28/2019</i>
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Violation Report: 42853 - 12/20/2018 - Duncan, Amy
 PCH Name: BROOKDALE LATROBE

1. REGULATION 55 Pa.Code §2600
 2600.102(l) - Shelves or hooks for the resident's towel and clothing shall be provided.

2a. DESCRIPTION OF VIOLATION

No hooks or towel racks are present in the shared bathroom of bedroom #12.

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.

Regulation 2600.102 (l)

Immediately, the Maintenance Director installed towel racks in the shared bathroom of room #12. These towel racks were individually labeled for each resident sharing the bathroom. Fresh towels were placed in the room.

February 21, 2019-The Executive Director retrained the appropriate staff regarding the need for each resident to have a designated towel rack in the shared bathrooms. The Maintenance Director conducted an audit of the shared bathrooms to verify there are designated towel racks for each resident sharing a bathroom.

The Executive Director reviewed the audit results and took actions as warranted based on the results of the audit. It was determined no further action was warranted at this time.

Evidence: Photo of towel racks in #12, training attendance sheet.

Completion date: February 28, 2019

Repeat Violation: No	Date(s) of Previous Violation(s):			
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Signature of Legal Entity Representative (Required on EVERY Page) *Roni Angus*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Roni Angus, E.D.</i>	Date <i>2/28/2019</i>
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Violation Report: 42853 - 12/20/2018 - Duncan, Amy

PCH Name: BROOKDALE LATROBE

1. REGULATION 55 Pa.Code §2600

2600.133(a)(1) - If the home serves nine or more residents, signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

2a. DESCRIPTION OF VIOLATION

The home currently serves 80 residents. There is no exit signs posted at the following emergency exit doors:

- *The door leading from the secured dementia care unit dining room to the personal care's outside enclosed courtyard
- *The double doors outside of the secured dementia care unit's dayroom leading to the personal care's rear courtyard
- *The double doors leading from the secured dementia care unit's dayroom to the secured dementia care unit's outside courtyard-

Violation Withdrawn *IA* 3/1/19

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.

Regulation 2600.00.133 (a) (1)

Immediately, the Maintenance Director posted signs to designate the doors to the courtyard are "not an Exit" in plain legible letters.

December 21, 2018-The Maintenance Director was retrained on the community policy regarding exit door signage by the Executive Director.

The Maintenance Director or designee will randomly audit to verify these signs remain in place. The Executive Director will determine if any further action is warranted based on audit results.

Evidence: picture of the signs, training attendance sheet

Completion date: February 21, 2019

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)

Koni Angus

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

Koni Angus, ED

Date

2/21/2019

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(Date)

The above plan of correction was approved by *IA*
(Initials)

Plan of correction implementation status as of 3/1/19
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress *IA*
- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 42853 - 12/20/2018 - Duncan, Amy
 PCH Name: BROOKDALE LATROBE

1. REGULATION 55 Pa.Code §2600

2600.184(a) - The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- (1) The resident's name.
- (2) The name of the medication.
- (3) The date the prescription was issued.
- (4) The prescribed dosage and instructions for administration.
- (5) The name and title of the prescriber.

2a. DESCRIPTION OF VIOLATION

Resident #1 is prescribed Lactase Caplet 3000unit tablet - Give 1 tablet orally 1 time a day, take with first bite of dairy; however, the pharmacy label indicates, Lactase Caplet 3000unit tablet - Take 1 to 3 tablets with first bite of dairy food.

Resident #1 is prescribed Novolog 100unit/1ML - Inject subcutaneously four times a day as per sliding scale: If 150-180 = 1 unit, 181-200 = 2 units, 201-250 = 3 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, for DM less than 70 or greater than 400, call MD. However, the pharmacy label does not indicate the sliding scale dosages.

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.

Regulation 2600.00.184 (a)

Immediately, the Health and Wellness Director clarified the order with the prescriber and had the pharmacy correct the label to correspond with the prescriber order.

December 21, 2018-The Health and Wellness Director retrained the appropriate staff regarding the community policy on Medication Administration. The Health and Wellness Coordinator or designee will audit eMAR orders to cart to verify needed medications are available weekly for 2 months then monthly thereafter.

Ongoing- The Health and Wellness Director will review audit results to verify if any further action is warranted.

Evidence: Training attendance sheet

Completion date: February 25, 2019

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Roni Angus*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Roni Angus, ED* Date *2/28/2019*

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Violation Report: 42853 - 12/20/2018 - Duncan, Amy
 PCH Name: BROOKDALE LATROBE

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

Resident #1's December 2018 medication administration record (MAR) indicates Furosemide 20 mg tablets - Give 2 tablets by mouth daily; however, the pharmacy label for the medication available in the home indicates Furosemide 40 mg tablets - Give 1 tablet by mouth daily.

Resident #3's December 2018 MAR indicates Magnesium Oxide tablet 200 mg - Give 1 tablet by mouth one time a day. However, the pharmacy label for the medication available in the home indicates Magnesium Oxide tablet 400 mg - Take 0.5 tablet (200 mg) by mouth every day.

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.

Regulation 2600.187 (a) The MAR's for residents #1 and #3 have been updated. *IA* 3/1/19

Immediately, the Health and Wellness Director clarified the order with the prescriber and had the pharmacy correct the label to correspond with the prescriber order.

February 25, 2019- The Health and Wellness Director retrained the appropriate staff regarding the community policy on Medication Administration.

The Health and Wellness Coordinator or designee will audit the eMAR orders to cart to verify needed medications are available weekly for 2 months then monthly thereafter. The Health and Wellness Director will review audit results and to verify if any further action is warranted.

Evidence: Training attendance sheet

Completion date: February 25, 2019

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative *Koni Angus*
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative *Koni Angus, RD* Date *2/27/2019*
 (Required on EVERY Page)

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Violation Report: 42853 - 12/20/2018 - Duncan, Amy
 PCH Name: BROOKDALE LATROBE

1. REGULATION 55 Pa.Code §2600

2600.227(d) - Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services.

2a. DESCRIPTION OF VIOLATION

Resident #3's most recent medical evaluation, dated 11/2/18, includes diagnoses of left ankle fracture, left knee sprain, neuropathy, stroke, HTN and gout; however, the resident's support plan, dated 12/3/18, does not address the services the home will provide regarding these diagnoses.

Resident #4's most recent medical evaluation, dated 5/7/18, includes diagnoses of HTN, GERD, osteoarthritis, hyperlipidemia, OAB, and constipation; however, the resident's support plan, dated 9/26/18, does not address the services the home will provide regarding these diagnoses.

Resident #5's most recent medical evaluation, dated 12/3/18, includes diagnoses of HTN, hydrocephalus and dementia; however, the resident's support plan, dated 7/9/18, does not address the services the home will provide regarding these diagnoses or the frequency of services hospice is providing for catheter care.

Resident #6's most recent medical evaluation, dated 1/30/18, includes diagnoses of Cerebral Palsy and GERD; however, the resident's support plan, dated 10/1/18, does not address the services the home will provide regarding these diagnoses.

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.

Regulation 2600.227 (d)

Immediately, the Health and Wellness Director updated the support plans to address the services the home is providing to meet the resident needs based on diagnosis... The Health and Wellness Director re-educated the appropriate clinical staff on the community policy regarding updating the support plans to include plans to meet the needs relating to all diagnoses.

Immediately- Health and Wellness Director completed the diagnosis form to include treatment plans to meet the needs of each diagnosis identified on the DME on the residents noted.

February 25, 2019 – Health and Wellness Director completed training for appropriate clinical staff on the community policy regarding inclusion of all resident diagnoses with corresponding plans to meet their needs.

Evidence: retraining attendance sheet, Resident #3, #4, #5 and #6's medical evaluation (DME) diagnoses along with the corresponding plan for services. Immediately: A designated staff person shall develop and implement a system to ensure all resident support plans are

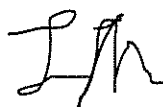
Completion date: February 28, 2019 immediately updated as resident care needs change. *IA* 3/1/19

Repeat Violation: No	Date(s) of Previous Violation(s):			
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Signature of Legal Entity Representative (Required on EVERY Page) *Roni Angus*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Roni Angus, ED* Date *2/20/2019*

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Violation Report: 42853 - 12/20/2018 - Duncan, Amy
 PCH Name: BROOKDALE LATROBE

1. REGULATION 55 Pa.Code §2600
 2600.231(f) - In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

2a. DESCRIPTION OF VIOLATION
 Resident #2 was admitted to the secured dementia care unit on 7/15/14; however, the resident's most recent assessment, dated 10/26/18, does not indicate the continued need to be served on the secured dementia care unit.

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.

Regulation 2600.231 (f)

Immediately the most recent assessment for resident #2 was updated to indicate the continued need for the resident to remain in a secure dementia unit which corresponds with the prescriber's documentation on the DME.

February 25, 2019- Executive Director retrained the Health and Wellness Director on documenting the continued needs of a resident to reside in a SCU on the DME as well as on the annual assessment, using an updated assessment to identify the resident's changing needs and assist the home become aware of the service which may change.

An audit of all annual reassessments for the past 2 months for residents in SCU will be audited for the completed DME with corresponding updated assessment.

The Health and Wellness Director will review the results of this audit to determine if any further action is warranted.

Evidence: Training attendance form, signed form for continued need to be served in the SCU, Current DME

Completion date: February 25, 2019

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Violation Report: 42853 - 12/20/2018 - Duncan, Amy
 PCH Name: BROOKDALE LATROBE

1. REGULATION 55 Pa.Code §2600
 2600.233(d) - Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

2a. DESCRIPTION OF VIOLATION
 At approximately 11:40 am, the magnetic lock for the gate in the secured dementia care unit courtyard was inoperable and the gate was unlocked. The courtyard opens into a parking lot.

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.

Regulation 2600.233 (d)

The Maintenance Director immediately repaired the magnetic lock on the gate in the courtyard.

December 21, 2018- The Executive Director re-trained the appropriate staff on the community policy regarding the courtyard magnetic lock.

The Maintenance Director or designee will audit the courtyard door for the functionality of the magnetic lock weekly for 2 months. The Executive Director will review the audit results to verify if any further action is required.

Evidence: Training log

Completion Date: February 25, 2019

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Roni Angus*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Roni Angus, ED</i>	Date <i>2/27/2019</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 3/1/19
 (Date)

The above plan of correction was approved by *LN*
 (Initials)

Plan of correction implementation status as of 3/1/19
 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress *LN*
- Partially Implemented - Inadequate Progress
- Not Implemented