pennsylvania
DEPARTMENT OF HUMAN SERVICES

September 12, 2019

Ms. Pamela Leland
Executive Director
The Hickman Friends Senior Community of West Chester
400 North Walnut Street
West Chester, Pennsylvania 19380

RE: The Hickman
License #: 140930

Dear Ms. Leland:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 12 & 13, 2019 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 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,

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *THE HICKMAN* License Number: *140930*
Address: *400 N WALNUT STREET, WEST CHESTER, PA 19380*
County: *CHESTER* Region: *SOUTHEAST*

Administrator

Name: *Pamela Leland* Phone: *4847606300* Email: *PLELAND@THEHICKMAN ORG*

Legal Entity

Name: *THE HICKMAN FRIENDS SENIOR COMMUNITY OF WEST CHESTER*
Address: *400 NORTH WALNUT STREET, WEST CHESTER, PA, 19380*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *05/14/1993* Issued By: *Department of L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *112* Waking Staff: *84*

Inspection

Type: *Full* BHA Docket #: Notice: *Unannounced*
Reason: *Renewal*

Inspection Dates and Department Representative

06/12/2019 - On-Site: Denise Gillespie, Michele Swisher

06/13/2019 - On-Site: Denise Gillespie, Michele Swisher

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* Residents Served: *73*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *22* Residents Served: *21*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *73*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *39*
Have Physical Disability: *0*

42s - Privacy

Regulations

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The camera located in the Hickman Sun Room hallway is angled so that the interior of resident # 1's bedroom, H223 is visible on camera. At 11:00am on 6/13/19, licensing representatives were able to view a recliner chair present in the bedroom. Staff Person A indicates that camera feeds are recorded and re-playable by the administration team. Cameras located in Hickman South 1st floor hallway, Hickman South 2nd Floor hallway, Hickman North 2nd floor hallway are also angled towards resident rooms.

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.)

While we fully understand the premise for the violation these cameras have been invaluable in helping to solve investigations concerning falls and ensuring optimal safety. Furthermore, doors to resident room are always closed during the provision of care to safeguard resident dignity and privacy. To ensure no further potential similar violation of privacy, Head of Security and Facilities Manager reviewed all camera angles on 7/25/2019 and "shaded" doorways of resident rooms to protect privacy of self and possessions. The camera angles are "fixed" and immoveable therefore this protection shall be sustained ongoing.

The Administrator will adhere strictly to the detailed regulatory requirements below, and conducts monthly review/audit on facility cameras to ensure ongoing compliance.

Audio and Video Monitoring - Audio monitoring in any location on the grounds of the home is prohibited.
Video monitoring and recording of the home's exterior is permitted.
Video monitoring of the home's interior common areas is permitted.
Video recording is permitted in interior areas completely inaccessible to residents, such as medication and supply storage areas.

Legal Entity Representative

Pamela Leland, Exec. Director 7/26/19

Signature | Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 8/7/19 (Date)

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

Plan of correction implementation status as of 8/7/19 (Date)

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

54a - Direct Care Staff

Regulations

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care Staff Person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

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 Person "B" was hired in 2017 and showed her status on the Nurse Aid Registry which was not maintained and has currently lapsed. You must have a High School Diploma or GED to be able to complete certification and be added to the Nurse Aid Registry therefore she indeed had the initial qualifications. An affidavit of High School Diploma has been certified by a Notary to attest that employee indeed has a High School Diploma. Moving forward HR Manger requires one of the 3 documents be provided pre-hire and also keeps a "tickler" file to remind current employees of upcoming renewals. An audit of existing employee files has also been performed by HR.

(ATTACHMENT 1)

Legal Entity Representative

Pamela Leland

Signature

Pamela Leland, Exec Director 7/26/19

Printed Name and Title Date

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

65a - FS Orientation 1st Day

Regulations

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.

Description of Violation

Staff person B, whose first day of work was 5/15/17 , did not receive orientation on any of the topics.

Staff Person C, whose first day of work was 5/15/18, did not receive orientation on any of the topics.

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.)

While we are certain that this training was completed as per regulation, we lack the documentation to prove it. There have been staff changes to this role and the current HR Manager ensures this training takes place on day 1 of orientation and furthermore ensures all staff complete initial and annual requirements as written in 2600.65

Employees have now received the cited training A.A.A

(ATTACHMENT 2)

On receiving this POC, the Administrator or a designee will review all employee's training record to ensure compliance with the cited reg. Administrator will create a checklist/tracking list for required employee's training, and audit staff's record quaterly to ensure continual compliance. 8/7/19

Legal Entity Representative

Pamela Leland Pamela Leland, Exec Director 7/26/19

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- ☐ Not Implemented

65b - Rights/Abuse 40 Hours

Regulations

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.

Description of Violation

Staff Person B completed his/her 40th scheduled work hour on 5/22/17. However, this staff person did not complete training in any of the topics.

Staff Person C completed his/her 40th scheduled work hour on 5/22/18. However, this staff person did not complete training in any of the topics.

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.)

While we are confident that we provided this training, we lack the documentation to provide evidence. There have been staffing changes made in our HR department and moving forward we now have systems in place to ensure both initial and annual training regulation are met or exceeded as written in 2600.65. HR manager has audited current files and will continue to do so on a quarterly basis.

(ATTACHMENT 2) Employees have now received the cited training A-A.A

On receiving this POC, the Administrator or a designee will review all employee's training record to ensure compliance with the cited reg. Administrator will create a checklist/tracking list for required employee's training to ensure continual compliance with the reg. For future transition, a checklist will be created to audit staff's records and ensure proper custody of records. 8/7/19

Legal Entity Representative

Pamela Leland, Exec Director 7/26/19

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- ☐ Not Implemented

65d - Initial Direct Care Training

Regulations

2600.

65.d. . Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:

Description of Violation

Direct Care Staff Person C, hired on 5/15/18, began providing unsupervised ADL services on 6/1/18. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

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.)

An audit of all existing staff has been performed by the HR Manager to ensure that all Direct Care Staff have indeed completed and passed the Department approved Direct Care Training Competency test. It has always been the policy to require documentation of the Nurse Aid Registry or Direct Caregiver Certification and moving forward the HR manager will require this documentation prior to any unsupervised ADL services.

Staff person "C" is no longer with facility, resigned 7/1/19

(ATTACHMENT 3)

The Administrator will develop a tracking/checklist for all employee's training , with the checklist indicating someone to verify training completion and compliance with the applicable reg. 8/14/19

A.A.A

Legal Entity Representative

Pamela Leland | Exec Director | 7/26/19

Signature | Printed Name and Title | Date

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- ☐ Not Implemented

65e - 12 Hours Annual Training

Regulations

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct Care Staff Person D received only 7.5 hours of annual training in training year January 1, 2018 to December 31, 2018.

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.)

While we are confident that we provided this training, we lack the documentation to provide evidence. There have been staffing changes made in our HR department and moving forward we now have systems in place to ensure both initial and annual training regulation are met or exceeded as written in 2600.65. HR manager has audited current files and will continue to do so on a quarterly basis.

(ATTACHMENT 4)

Staff D, completed a total of 11.5 hours of training for 2018 and will need additional 0.5 hours ; in addition to the required 12 hours of annual training for the 2019 training years to be in compliance. 8/7/19

A.A.A

Legal Entity Representative

Pamela Leland — Pamela Leland, Exec Director — 7/26/19

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- ☐ Not Implemented

65f Training Topics

Regulations

2600.

65.f. . Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.

Description of Violation

Direct Care Staff Person D did not receive training in

1. Medication self-administration. 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. 3. Personal care service needs. 4. Safe management techniques.

During training year January 1, 2018 to December 31, 2018.

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.)

While we are confident that we provided this training, we lack the documentation to provide evidence. There have been staffing changes made in our HR department and moving forward we now have systems in place to ensure both initial and annual training regulation are met or exceeded as written in 2600.65. HR manager has audited current files and will continue to do so on a quarterly basis. As you can see all topics are included in the 2019 Plan.

(ATTACHMENT 4) The Administrator will create a training checklist/tracking list that will prompt the need for all regulatory required trainings to be completed. Quarterly audit of all employee's training record will be conducted. The Employee has received the cited training for year 2019. 8/14/19

A-A.A

Legal Entity Representative

Pamela Leland — Pamela Leland, Exec Director — 7/26/19

Signature — Printed Name and Title — Date

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- ☐ Not Implemented

65g - Annual Training Content

Regulations

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. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite 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.

Description of Violation

Staff Person D did not receive training in The Older Adult Protective Services Act during training year January 1, 2018 to December 31, 2018.

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.)

While we are confident that we provided this training, we lack the documentation to provide evidence. There have been staffing changes made in our HR department and moving forward we now have systems in place to ensure both initial and annual training regulation are met or exceeded as written in 2600.65. HR manager has audited current files and will continue to do so on a quarterly basis. As you can see by the attachment, all topics are included in the 2019 Plan.

(ATTACHMENT 4) A-A.A

On, receiving this POC, and with immediate effect, staff person D will be trainned on " Older adult protective act" as required by the cited reg. 8/14/19

Legal Entity Representative

Pamela Leland Pamela Leland Exec Director 7/26/19

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- ☑ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

101j7 Lighting/Operable Lamp

Regulations

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident Room J219 does not have access to a source of light that can be turned on/off at bedside.

Resident Room H106 does not have access to a source of light that can be turned on/off at bedside.

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.)

In both cases, the resident opted to place the light source in another location within the room. To accomplish the requirements of this regulation, on 7/1/2019 the Facilities Manager installed wall mounted LED light switches at both bedsides and will continue to provide this option for those residents who do not wish to have a lamp on the bedside table. All residents in attendance at the Resident Meeting on 7/24/2019 were informed that this option was available. Moving forward, facilities staff will monitor compliance upon move in and routinely thereafter.

(ATTACHMENT 5)

The Administrator will ensure that, the requirements of the cited regulation will be included in the checklist of things to monitor for compliance during a daily walkthrough of the facility. 8/7/19

A.A.A

Legal Entity Representative

Pamela Leland — Pamela Leland, Exec Director — 7/26/19

Signature — Printed Name and Title — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

105g - Lint Removal and Duct Cleaning

Regulations

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 6/12/19, there was an accumulation of lint in the lint trap of 3 dryers in the Jeanes Building. There were no clothes in the dryer at the time.

On 6/13/19, there was an accumulation of lint in the lint trap of the secured dementia care unit dryer. There were no clothes in the dryer at the time.

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.)

Signage has been placed on each dryer to remind residents, staff and families of the importance of removing lint after each use. Lead staff in the SDU are assigned to check the dryer vent daily and facilities staff will check all dryers daily throughout the building. Facilities manager will perform routine checks to ensure compliance.

(ATTACHMENT 5 & 6)

The Administrator or a designee willl create a checklist to indicate the date, time and staff person that completed the routine dryer lint check to ensure ongoing compliance with the cited reg. 8/7/19

A.A.A

Legal Entity Representative

Pamela Leland Pamela Leland Exec Director 7/26/19

Signature | Printed Name and Title | Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

127a - Portable Space Heaters

Regulations

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 6/13/19 at 11:00 A.M., a portable space heater was in use in H106.

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.)

Although space heaters are prohibited from use and we have a policy to support this, this unit was in use as a "table" and not recognized by staff. Re-in serviced all direct Care staff as well as facilities and housekeeping providing a visual of potentially "disguised" pieces. All residents in attendance at the Resident Meeting on 7/24/19 were reminded and a flyer was sent to families/residents reminding them that not only space heaters, but electric blankets, and heating pads were prohibited as well.

(ATTACHMENT 5 & 7)

The Administrator or a designee will conduct periodic checks on the facility to ensure ongoing compliance with the cited regulationl 8/7/19

A-A.A

Legal Entity Representative

Pamela Leland

Signature

Pamela Leland Exec Director

Printed Name and Title

7/26/19

Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

181d -Storing Medication

Regulations

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident # 2 self-administers medications and stores medications in his/her room. On 6/13/19 at 10:45 A.M., there were several unlocked, unattended medications in Resident #2's bedroom.

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 self-medication Assessment is performed by a nurse quarterly for continued safety assessment for residents that self-medicate. The form has been updated to include a "check off" that the medication is kept behind a locked door or in a locked container as well as a highlighted excerpt from the regulations for the resident to sign. All residents were reminded of this at the Resident meeting which took place on 7/25/2019.

(ATTACHMENT 8)

Administrator or a designee will include the need to check for unlocked medications in the checklist of things to monitor during a daily walkthrough of the facility. 8/7/19

A.A.A

Legal Entity Representative

Pamela Leland | Pamela Leland, Exec Director | 7/26/19

Signature | Printed Name and Title | Date

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224a - Preadmission Screen Form

Regulations

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.

Description of Violation

Resident #3 was admitted to the home on 9/18/18; however, the resident's preadmission screening form does not have a date indicating when the form was completed.

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.)

It is standard practice to perform the screening on the prescribed form within the regulated time frame. We are confident this took place however the date was omitted from the form. The Nurse Manager will ensure forms are completed in their entirety and the Director of Resident Care will perform a quarterly audit to ensure current and future compliance.

The Administrator or a designee will create a checklist that will prompt the need for a pre-admisison form to be completed as stipulated in the cited reg. The checklist will indicate the designated person to verify a dully completed form including the date of completion. 8/7/19

A.A.A

Legal Entity Representative

Signature | Pamela Leland, Exec Director | 7/26/19
Printed Name and Title | Date

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- ☐ Not Implemented

227g -Support Plan Signatures

Regulations

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3 participated in the development of his/her support plan on 9/19/18. However, the resident did not sign the support plan.

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.)

It is standard practice to encourage participation in formulation of support plans by the residents. In this case the nurse failed to get the resident to sign the form. An audit of all Support plans was conducted and New Support Plans will be audited for completion by the Director of Resident Services.

The Administrator or a designee will create a checklist that will prompt the need for all regulatory requirements to be completed pertaining to resident's admission and support plans. 8/7/19

A.A.A

Legal Entity Representative

Pamela Leland, Exec Director 7/26/19

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231c - Preadmission Screening

Regulations

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on 5/17/18. However, the Resident 4's written cognitive preadmission screening was completed on 3/27/18.

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.)

Our new SDU was scheduled to open on 4/1/2018 however, there was a delay in opening. This paperwork was completed in anticipation of that date and not updated to comply with the 72 hour rule. This form could have easily been redone by our Dementia Unit Program Manager, Nurse or Director of Resident Care and was simply a paper compliance oversight. A new move in process has been established and theNurse/ Program Manager assures all necessary documents are completed pre-move in. The Director of Resident Services Will also audit all charts routinely.

On recieving this POC, the Administrator will review all resident's admission document for accuracy.The Administrator, or a designee will create a checklist that will prompt the need for all regulatory requirements to be completed for all residents being admitted to the SDCU. The checklist will require the Administrator or a designee to verify that all regulatory requirements pertaining to an Admisison to the SDCU have been completed. 8/7/19

A-A.A

Legal Entity Representative

Pamela Leland — Pamela Leland Exec Director — 7/26/19

Signature | Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of (Date)
06/12/2019

The above plan of correction was approved by A.A.A (Initials) 8/7/19

Plan of correction implementation status as of 8/7/19 (Date)

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

231.c - Preadmission Screening

Regulations

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Addendum: Attached please find DME dated for 3.27.18 with an update to the SDU section by Dr. Fronduti on 5/16/2018. It is clear that the DME was updated for 5/16/2018 however Dr. Fronduti dated the determination for the initial visit date of 3/27/2018. Please note the "timestamp" at the top of all 3 pages indicating 5/16/2018 which was the date received.
(Attachment 14.15 &16)

Legal Entity Representative

Antoinette M. Kelly

Signature

Antoinette M. Kelly LPN, RCHA 8/12/19

Printed Name and Title Date