pennsylvania
DEPARTMENT OF HUMAN SERVICES

October 18, 2019

Mr. John D. Dougherty, Administrator
Ms. Kathleen Dougherty, Administrator
Washington Manor Personal Care Home, LLC
320 South Washington Street
Butler, Pennsylvania 16003

RE: Washington Manor
Personal Care Home, LLC
License #:448630

Dear Mr. and Ms. Dougherty:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 18, 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: *WASHINGTON MANOR PERSONAL CARE HOME LLC* License Number: *44863*
Address: *320 SOUTH WASHINGTON STREET, PO BOX 1935, BUTLER, PA 16003*
County: *BUTLER* Region: *WESTERN*

Administrator

Name: *John D. Doughtery* Phone: *7242858115* Email: *WMPCH@ZOOMINTERNET NET*

Legal Entity

Name: *WASHINGTON MANOR PERSONAL CARE HOME LLC*
Address: *320 SOUTH WASHINGTON STREET, P O BOX 1935, BUTLER, PA, 16003*

Certificate of Occupancy

Type: *C-2 LP* Date: *07/24/1985* Issued By: *LABOR AND INDUSTRY*

Staffing Ratio

Resident Support Staff: Total Daily Staff: *25* Waking Staff: *19*

Inspection

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

Assistant Person and Department Representative

06/18/2019 - On-Site: Laurie Garrigan, Barbara Barone

Resident Person and Date of Occupation Data

General Information

License Capacity: *25* Residents Served: *25*

Special Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Census

Current Residents: *0*

Number of Residents With

Receive Supplemental Security Income: *23* Are 60 Years of Age or Older: *11*
Diagnosed with Mental Illness: *25* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *0* Have Physical Disability: *0*

Post Current License

Rule Cited

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

At 10:24 a.m., the most recent Licensing Inspection Summary, dated 7/2/18, was not posted in the home.

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 2a JH 9/13/19

Legal Entity Representative

John D. Dougherty Adm 07-28-19

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 9/13/19 (Date)

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

Plan of correction implementation status as of 9/13/19 (Date)

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

PLAN OF CORRECTIONS

2600.3.c.

The administrator had the current license in the frame in a public area but not the current inspection report but, instead, the two prior inspections. To ensure this doesn't occur again in the future the administrator will add to the Quarterly Management Team meeting agenda to review that proper documentation such as the posting of the current license and plan of corrections is posted to abide by this regulation. This oversight was corrected while the inspectors were present during the inspection and the inspection summary is in the public area.

The administrator or designated staff person will conduct weekly checks of the home to ensure that the current license inspection summary issued by the Department is posted in a conspicous and public place in the home in accordance with §2600.3(c). In addition, all new licensing inspection summaries received will be posted immediately upon receipt. JD 9/13/19

John D. Dougherty
Administrator
07/28/2019

RECEIVED
AUG 11 2019
WEST REGION FIELD OFFICE
Human Services Licensing

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.

Direct care staff A, hired 2/22/19, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry. However, the staff person worked unsupervised assisting residents with activities of daily living (ADLs) during the 3:00 p.m. to 11:00 p.m. shift on 6/13/19, 6/14/19, 6/15/19 and 6/17/19.

(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 3a JH 9/13/19

Signature

John D. Dougherty Admr 09-28-19
Printed Name and Title Date

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2600.54.a

The care home does not agree with this violation. Direct care staff A did provide his high school diploma as was noted prior to the inspectors arrival by the administrator on one of the training pages. Either the copy of the document was handed back in error with the original to direct care staff person A or misplaced during review of the files. Direct staff person A has been directed to bring in his diploma again (see attached). It shows staff person A graduated in 1980. In addition on the 3 p.m. to 11:00 p.m. shift staff person A wasn't working alone on their shift but with another direct care member. A copy of the staff schedule was given for these dates during inspection and is again attached with this response (see attached). To ensure the care home remains in good standing on this regulation the administrator will continue monthly staff file reviews of new and current employee qualifications. Quarterly Management Team will implement a monitoring system to ensure education qualifications before a staff member provides care in further support to stay in compliance with this regulation.

John D. Dougherty
Administrator
07/28/2019

(56) - 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:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Staff person B did not complete the Department-approved direct care training course and pass competency test until 4/18/19. However, the staff person provided unsupervised assistance with ADLs to residents during the 7:00 a.m. to 3:00 p.m. shift on 3/11/19, 3/12/19 and 3/14/19.

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 4a JH 9/13/19

Legal Entity Representative

[signature] JOhn D-Dougherty Adm 07-28-19

Signature | Printed Name and Title | Date

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- ☐ Not Implemented

2600.65.d

Staff person B had major hip surgery shortly after being hired and did not return to work until 03-11-2019. The administrator during his review of staff files realized that staff person B had not completed the direct care training course and had it done immediately. To ensure future compliance with this regulation the administrator will review staff files as has been done but now, if an employee is out for health reasons for a term, review the staff person's file prior to return to work duties.

Within 30 days of receipt of this plan of correction, the administrator or designated staff person responsible for hiring and training staff will review all staff records to ensure all staff have completed the direct care training cource and passed the competency test in accordance with §2600.65(d). JD 9/13/19

John D. Dougherty
Administrator
07/28/2019

C - Statutory Citation(s)

2600.
85.a. Sanitary conditions shall be maintained.

D - Description of Violation(s)

At 10:32 a.m., there was ¼" of black mold on the bottom surface of the clear shower mat in the shower of the first floor common bathroom, located near the television living area.

E - 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 5a JH 9/13/19

Legal Entity Representative

John D. Dougherty — John D. Dougherty Admr 08-28-19

Signature — Printed Name and Title — Date

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2600.85.a

The care home disagrees with some of the details of this violation. For it to be stated with confidence that a ¼ inch of mold covered the bottom of the shower mat is ridiculous and untrue. The administrator was standing with the inspector and the shower mat was clear in design which allowed you to see the bottom by looking in the shower. The mat did have spots of mold but the entire bottom was not ¼ inch thick as stated and no measurement was ever conducted. The mat was removed by the administrator and replaced while the inspectors were present with a new mat. Mold can form quickly under these mats and is on the physical site checklist to be checked weekly (see attached). To avoid any future violation with this regulation the administrator has replaced the shower mat with non-slip shower floor treads were mold cannot form underneath (see attached). In addition to ensure future compliance a review of maintaining proper sanitary conditions will accompany each monthly staff required training already being conducted.

John D. Dougherty
Administrator
07/28/2019

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

At approximately 11:25 a.m., the home's first aid kits in the kitchen and medication room did not include a breathing shield.

(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 6a JH 9/13/19

John D. Dougherty — John D. Dougherty Admr — 09-28-19
Signature — Printed Name and Title — Date

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2600.96.a

The care home has on the physical site checklist a monthly check of the first aid kit to stay in compliance with this regulation prior to inspection (see attached). The administrator at the time of inspection did not find the breathing shield with the first aid kit and ordered two new ones providing proof to the inspectors that this was done while present (see attached). The shield was found in a drawer away from the first aid kit afterwards and apparently was moved by staff between monthly inspections. The old mask was immediately added to the first aid kit when found and the two new ones were added as well when they arrived. Staff has been directed to not move items from the first aid kit that are not in use and placing them elsewhere (see the attached posting). The administrator will continue monthly checks using the physical site checklist to ensure compliance with this regulation in the future.

John D. Dougherty
Administrator
07/28/2019

Type of Fire Drill Record

Regulation

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill record only indicates "number of residents" for the following fire drills and does not specify the number of residents in the home at the time of the drill and the number of residents evacuated:
*1/26/19 at 11:06 a.m.
*2/23/19 at 1:53 p.m.
*3/16/19 at 12:36 a.m.
*4/19/19 at 10:35 a.m.
*5/25/19 at 2:20 p.m.

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 7a JH 9/13/19

Legal Entity Representative

John D. Dougherty | John D. Dougherty Adm | 01-28-19
Signature | Printed Name and Title | Date

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- ☐ Not Implemented

2600.132.c.

The fire drill log/sheet used to document does state the number of residents that were in the home (disagree with violation on this area) but didn't have a column stating the number of residents evacuated (see attached). The care home fire log original that was always used prior to 01/26/2019 could not be found to make a copy, so a copy of another log was found and used to document the drills conducted. Since the inspection the original fire log sheet has been found and is in use showing the number of residents evacuated and will continue to be used by the administrator to ensure no future violations with this regulation.

At least monthly, the administrator or designated staff person will review the fire drill records to ensure that the number of residents evacuated is documented on the fire drill record as well as all other information specified in §2600.132(c). 9/13/19

John D. Dougherty
Administrator
07/28/2019

F-Tag - Annual Medical Evaluation

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description

Resident #1's medical evaluation, signed by the physician on 2/7/19, did not include the date the resident was evaluated, the date the form was completed, the resident's date of birth, height or weight. These sections of the form were blank.

Resident #2's medical evaluation, dated 5/9/19, did not include the resident's height and weight. These sections of the form were blank.

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 8a JH 9/13/19

Legal Entity Representative

John D. Dougherty — Signature

John D. Dougherty Adm 07-28-19 — Printed Name and Title / Date

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2600.141.b.1

The care home has had difficulty receiving cooperation from physicians to fill in all areas of the medical evaluation. The medical evaluation forms were fixed on 06-18-2019. To ensure future compliance with this regulation the Quarterly Management Team is going to review all resident records for accuracy and completion during their meetings.

Within 30 days of receipt of this plan of correction, and monthly thereafter, the administrator or designated staff person will review all resident records to ensure medical evaluation forms were completed timely and accurately. JD 9/13/19

John D. Dougherty
Administrator
07/28/2019

183.1 Prescription Drugs

Regulation:

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Deficiency Statement

The following medications for resident #3 were discontinued; however, they were still present in the home:
*Venlafaxine HCL 150 mg 24-hour SA capsule-take 1 capsule by mouth every morning.
*Cyanocobalamin 1000 mcg tablet-take 1 tablet by mouth every day.

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 9a JH 9/13/19

Legal Entity Representative

John D. Dougherty — John D. Dougherty Admin 07-28-19
Signature — Printed Name and Title — Date

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Plan of correction implementation status as of 9/13/19 (Date)

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

2600.183.d

Resident #3 is a VA resident (only one we have) and calls in to his physician whom sends out the medication order. The care home uses Mission Pharmacy and the VA physician for resident #3 has been uncooperative in contacting Mission Pharmacy to update the EMAR so it coordinates with the medication the VA physician ordered sent from the VA Pharmacy. After numerous phone calls the care home finally received cooperation from the VA and Mission Pharmacy finally received an update for the EMAR system to match the medications on hand. The medications given to resident #3 were what the VA physician wanted him to receive but the EMAR was not accurate. To ensure future compliance with this regulation the care home manager/administrator will continue contacting the VA to update the EMAR system for resident #3 if/when medication changes occur. The discontinued medications found not to be discontinued with the updated EMAR were used as directed by the physician, any discontinued meds were discarded. On each Sunday the administrator, manager and direct care staff employee are reviewing resident #3's EMAR for accuracy to ensure future compliance with this regulation.

Within 30 days of receipt of this plan of correction, all staff persons responsible for administering medications will be educated on ensuring that only current prescriptions, OTC, sample and CAM for individuals living in the home are kept in the home in accordance with §2600.183(d). JD 9/13/19

John D. Dougherty
Administrator
07/28/2019

(X4) ID PREFIX TAG	(X5) COMPLETION DATE

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

4. The prescribed dosage and instructions for administration.

(X4) ID Summary of Violation

On 4/19/19, resident #3 was prescribed Divalproex "ER" 250 mg tablet- take 3 tablets (750 mg) by mouth once a day. However, the pharmacy label on the medication indicates Divalproex "ER" 250 mg- take 1 tablet by mouth three times a day for 3 days, then take1 tablet twice a day for 3 days, then take one tablet every day for 3 days.

Plan of Correction (X5)

(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 10a JH 9/13/19

Legal Entity Representative

John D-Dougherty — John D-Dougherty Admr 09-18-19

Signature — Printed Name and Title — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

2600.184.a

On 6/22/19, the administrator got a new prescription from the physician and had the medication updated on the EMAR to match the label. JH 9/13/19

The label on the medication is correct and resident #3 was receiving the medication as the VA physician prescribed. Problem the care home has is that the VA physician sends medications to resident #3 from the VA Pharmacy and is extremely uncooperative in contacting Mission Pharmacy, whom the care home uses, to update the EMAR system with medication changes. The care home manager and administrator finally received cooperation from the VA after numerous requests. To avoid future violations with this regulation the administrator and manager are watching resident #3's medications to find any discrepancies with the EMAR and contact the VA immediately to get the EMAR corrected if/when changes occur.

At least monthly, a staff person qualified to administer medications will audit the home's medication carts to ensure that all medications are correctly labeled and that the label includes the prescribed dosage and directions for adminstration that match the precriber's orders. JH 9/13/19

John D. Dougherty
Administrator
07/28/2019

185a. Implement Storage Procedures

Regulations

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 4/16/19, resident #2 was prescribed daily blood sugar checks; however, on 5/1/19 and 6/5/19 the home had no documentation that the resident's blood sugar was checked. On 6/5/19, at 8:44 a.m., the resident's glucometer reading was 95; however, the home had no documentation of this reading on the resident's blood sugar reading record.

On 4/19/19, resident #3 was prescribed Trazodone 100 mg tablet-take 1 tablet by mouth at bedtime as needed. However, this medication was not available in the home.

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 11a JH 9/13/19

Legal Entity Representative

John D. Dougherty
Signature

John D. Dougherty Adm 07-28-19
Printed Name and Title — Date

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- ☐ Not Implemented

2600.185.a

Resident #2's blood sugar is checked daily but some direct care staff members failed in recording the readings on the above dates as they're supposed to do. The manager and administrator have reviewed the importance of properly recording resident #2's blood sugar checks with staff and are checking the record daily for any missed readings from staff to address the issue to stay in compliance with this regulation. In addition besides daily checks of the glucometer to ensure proper recording this issue will be reviewed each monthly staff training to emphasize the importance with staff and ensure future compliance with this regulation.

Resident #3 was no longer prescribed Trazodone at the time of inspection and the EMAR was incorrect. The VA physician for resident #3 discontinued the medication but has been very uncooperative in contacting the care home's pharmacy (Mission Pharmacy) to update the EMAR to match the medications sent from the VA. The care home administrator and manager finally received cooperation after numerous requests to the VA on the update of the EMAR and are monitoring resident #3's medications to make sure they match the EMAR. If/ when changes occur the VA again will be contacted to send Mission Pharmacy the accurate information for the EMAR.

John D. Dougherty
Administrator
07/28/2019

ID Prefix Tag	Regulation Cited
	2600. 190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C did not complete an annual practicum for medication administration due on 4/1/19. However, the staff person passed multiple medications to multiple residents in June 2019 to include the following of resident #3's 8:00 a.m. medications on 6/14/19, 6/16/19 and 6/18/19:

- Fluticasone Prop 50 mcg spray administer 2 sprays into each nostril once a day
- Gabapentin 800 mg tablet take 2 tablets (1600 mg) by mouth twice a day
- Hydroxyzine HCL 10 mg tablet take 1 tablet by mouth three times a day

Plan of Correction

(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 12a JH 9/13/19

Facility Representative

John D. Dougherty John D. Dougherty Admr 09-28-19

Signature | Printed Name and Title | Date

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- ☐ Not Implemented

2600.190.a

Staff member C did complete the annual practicum, the documentation was found shortly after the inspection (see attached). The care home disagrees with this violation since proof of completion has been provided and the administrator will continue to review staff files to have timely completion of annual practicum's conducted.

John D. Dougherty
Administrator
07/28/2019

WASHINGTON MANOR PERSONAL CARE HOME LLC 44863

F 225 - Assessment 15 Days

Regulation

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3 was admitted to the home on 4/19/19. However, his initial assessment was not completed until 5/17/19.

Resident #4 was admitted to the home on 3/19/19. However, her initial assessment was not completed until 4/18/19.

Repeat 7/2/2018 et.al.

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 13a JH 9/13/19

Facility Representative

John D. Dougherty — Signature

John D. Dougherty — Printed Name and Title

08-28-19 — Date

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- ☐ Not Implemented

2600.225.a

Administrator delegated the completion of initial assessments for resident #3 and #4 to the manager whom misunderstood the regulation timeline for completion. To ensure future compliance with this regulation the administrator will complete all initial assessment's for future residents. Additionally all new residents assessments will be reviewed by the administrator within 10 days to check plus the Quarterly Management Team will review new resident files monthly to ensure compliance.

Within 30 days of receipt of this plan of correction, and ongoing, all staff responsible for the completion of initial assessements will be educated on the timeframes specified in §2600.225(a). 9/13/19

John D. Dougherty
Administrator
07/28/2019

225.c - Additional Assessment

Regulation

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's annual assessment, signed on 9/28/18, was undated in the section titled finalized. This section of the assessment was blank. The assessment also did not include the diagnoses of psychosis, bipolar disorder, acid reflux and left-hand contractures as the home failed to complete an additional assessment upon receiving these diagnoses with the resident's most recent medical evaluation form signed on 2/7/19.

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 14a JH 9/13/19

Legal Entity Representative

John D. Dougherty — Signature

John D. Dougherty Admr 07-25-19 — Printed Name and Title / Date

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The above plan of correction is approved as of 9/13/19 (Date)

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

Plan of correction implementation status as of 9/13/19 (Date)

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

2600.225.c

The Quarterly Management Team will meet to review annual assessment/ recent residents medical evaluation forms to note proper documentation and changes in diagnosis to ensure compliance with this regulation. The record was corrected on 06-18-2019 and the Quarterly Management Team will be pulling all files monthly to review to ensure compliance with this regulation.

Within 30 days of receipt of this plan of correction, and ongoing, all staff responsible for conducting resident assessments with be educated on the importance of updating resident assessments when the condition of the resident significantly changes prior to the annual assessment in accordance with §2600.225(c)(2). JD 9/13/19

John D. Dougherty
Administrator
07/28/2019

227d - Support Plan Medical/Dental

Regulation

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. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #1's support plan signed on 9/28/18 includes a diagnosis of Borderline Intellect; however, the support plan indicates N/A for the plan to meet the psychological needs. The support plan also includes a diagnosis of Schizophrenia for this resident; however, the support plan is blank under frequency and responsible party.

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 15a JH 9/13/19

Legal Entity Representative

John D. Dougherty — John D. Dougherty Admin 08-28-19

Signature — Printed Name and Title — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

2600.227.d

The care home's Quality Management Team will review all support plans for accuracy/changes in condition that should be properly documented/updated to ensure future compliance with this regulation. The correction was made to this documentation on 06-18-2019 and the Quarterly Management Team will be reviewing all resident files monthly to ensure future compliance with this regulation.

John D. Dougherty
Administrator
07/28/2019