pennsylvania
DEPARTMENT OF HUMAN SERVICES

November 26, 2019

Mr. Christian N. Cummings
President
EC OPCO Lewisburg, LLC
Eclipse Sr Living ATTN Licensing
5885 Meadows Road, Suite 500
Lake Oswego, Oregon 97035

RE: Elmcroft of Lewisburg
2421 Old Turnpike Road
Lewisburg, Pennsylvania 17837
License #: 227200

Dear Mr. Cummings:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 19, 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 : *ELMCROFT OF LEWISBURG* **License Number :** *227200*

Address : *2421 OLD TURNPIKE ROAD, LEWISBURG, PA 17837*

County: *UNION* **Region:** *NORTHEAST*

Administrator

Name : *AMANDA GRESH* **Phone :** *5705247999* **Email :** *AGRESH@ELMCROFT.COM*

Legal Entity

Name : *EC OPCO LEWISBURG LLC*

Address: *5885 MEADOWS ROAD SUITE 500, LAKE OSWEGO, OR, 97035*

Certificate(s) of Occupancy

Type : *C-2 LP* **Date :** *10/13/1998* **Issued By :** *L&I*

Staffing Hours

Resident Support Staff : *0* **Total Daily Staff :** *44* **Waking Staff :** *33*

Inspection

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

Reason: *Renewal*

Inspection Dates and Department Representative

06/19/2019 - On-Site: Jason Harvey, Ryan Novak

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *73* **Residents Served :** *39*

Secured Dementia Care Unit

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

Hospice

Current Residents : *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older : *39*
Diagnosed with Mental Illness : *3*
Diagnosed with Intellectual Disability : *0*
Have Mobility Need : *5*
Have Physical Disability : *0*

41d - Rights/Complaint Procedures

Regulations

2600.

41. d. A copy of the resident's rights and complaint procedures shall be given to the resident and, if applicable, the resident's designated person upon admission.

Description of Violation

The list of resident's rights in the contract for Resident #1 and #2 do not include the right to refuse medication if the resident believes there is an error.

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

Action: June 28th Revised Contract Addendum E (see attached Addendum E, Section C), which includes right to refuse, used in contract signings, effective July 2019. Residents right to refuse medication will be reviewed at Resident Council in August 2019.

Training: Administrator will educate all staff responsible for contract signing to include the requirements of regulation 2600.65.a. The education will be completed by 08/31/2019.

Monitoring: Executive Director or designee to monitor for compliance.

Legal Entity Representative

Amanda Gresh
Signature

Amanda Gresh Administrator 8/16/19
Printed Name and Title Date

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

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

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

Plan of correction implementation status as of 8-19-19 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ 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:

Description of Violation

Staff person A (hired 4/29/19) did not receive the training required to be completed on or before the first day of work.

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.)

Action: Staff person A completed the required training day of inspection, 06/19/2019. Attached is the support documentation of training for staff A. An audit of all current staff training will be completed by 08/31/2019 to ensure all employees have documentation of all required training.

Training: Administrator will educate all staff responsible for new hire training to include the requirements of regulation 2600.65.a. The education will be completed by 08/31/2019.

Monitoring: Administrator or designee will monitor all new hire documents to ensure compliance with regulation 2600.65.a.

Legal Entity Representative

Amanda Gresh Amanda Gresh Administrator 8/16/19

Signature Printed Name and Title Date

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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:

Description of Violation

Staff person A (hired 4/29/19) did not receive the required training that is to take place within the first 40 working hours.

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.)

Action: Staff person A completed the required training day of inspection, 06/19/2019. Attached is the supporting documentation of training. An audit of all current staff training will be completed by 08/31/2019 to ensure all employees have documentation of all required training.

Training: Administrator will educate all staff responsible for new hire training to include the requirements of regulation 2600.65.b. The education will be completed by 08/31/2019.

Monitoring: Administrator or designee will monitor all new hire documents to ensure compliance with regulation 2600.65.b.

Legal Entity Representative

Amanda Kirsch — Signature

Amanda Gresh Administrator — Printed Name and Title

8/16/19 — Date

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- ☐ Not Implemented

65d - Initial Direct Care Training

Regulations

2600.

65. d. 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on 4/29/19, began providing unsupervised ADL services. 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.)

Action: Staff person A completed and passed the department approved direct care training course on day of inspection, 06/19/2019. An audit of all current staff training will be completed by 08/31/2019 to ensure all employees have taken the DHS competency test.

Training: Administrator will educate all staff responsible for new hires on the required 2600.65.d.2 training. The education will be completed by 08/31/2019.

Monitoring: Administrator or designee will monitor all new hire documents to ensure successful completion of regulation 2600.65.d.2.

Legal Entity Representative

Signature

Amanda Gresh Administrator
Printed Name and Title

8/16/19
Date

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65f - Training Topics

Regulations

2600.

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

Description of Violation

Direct care staff person B did not receive training in Medication self-administration training and Infection Control during training year 2018.

Direct care staff person C did not receive training in Medication self-administration training during training year 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.)

Action: Staff person B and staff person C received the required training for regulation 2600.65.f. Attached is the supporting documentation of staff B completing medication self-administration training, infection control training and staff person C completing the medication self-administration training.

Training: Administrator will educate all staff responsible for training on the required 2600.65.f. training. The education will be completed by 08/31/2019.

Monitoring: Administrator or designee will monitor training documentation to ensure successful completion of regulation 2600.65.f. Training requirements are reviewed at monthly QA meeting.

Legal Entity Representative

Amanda Gresh — Signature

Amanda Gresh Administrator — Printed Name and Title

8/16/19 — Date

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103e - Left Overs

Regulations

2600.

103. e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

A bag of meatballs, tater tots and chicken fingers were in the freezer in the main kitchen that were not labeled.

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.)

Action: Bag of meatballs, tater tots and chicken fingers were labeled and dated day of inspection, 06/19/2019.

Training: Administrator or designee will educate all staff that are responsible for labeling and dating food items of regulation 2600.103.e. Education will be completed by 08/31/2019.

Monitoring: Administrator or designee will monitor food inventory to ensure labeling and dating for ongoing compliance at a minimum of weekly.

Legal Entity Representative

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Amanda Gresh Administrator — Printed Name and Title

8/16/19 — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

121a - Unobstructed Egress

Regulations

2600.

121. a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 6/19/19 at 9:50am, the exit door located in the home's dining room would not open with ease while exiting the door.

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.)

Action: Maintenance Director cleaned door frame and sprayed latch with lubrication day of inspection, 06/19/2019.

Training: Administrator will educate Maintenance Director on regulation 2600.121.a. Education will be completed by 08/31/2019.

Monitoring: Administrator or designee will monitor weekly to ensure compliance with regulation 2600.121.a.

Legal Entity Representative

Amanda Gresh — Signature

Amanda Gresh Administrator — Printed Name and Title

8/16/19 — Date

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- ☐ Not Implemented

125a - CombustibleStorage

Regulations

2600.
125. a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A small black pillow case was located behind the dryer on the dryer duct, posing a possible fire hazard.

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.)

Action: Small black pillow case was removed from behind the dryer on the dryer duct day of inspection, 06/19/2019.

Training: Administrator will educate all staff that are responsible for the laundry department to ensure compliance with regulation 2600.125.a. Education will be completed by 08/31/2019.

Monitor: Administrator or designee will assure dryer duct is free of materials daily.

Legal Entity Representative

Amanda Gresh — Signature

Amanda Gresh Administrator — Printed Name and Title

8/16/19 — Date

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- ☐ Not Implemented

132h - Designated Meeting Place

Regulations

2600.

132. h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drills on 6/28/18, 5/20/19, 9/30/18 and 10/31/18 one resident did not evacuate their room to a designated meeting place.

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.)

Action: Elmcroft of Lewisburg takes resident safety very seriously, staff will continue to educate and monitor all residents on the importance of evacuating their room to a designated meeting place. Above resident has since been discharged. Administrator or designee will audit 2019 fire drill records to ensure compliance with regulation 2600.132.h.

Training: Administrator will educate all staff on regulation 2600.132.h. to ensure compliance. Training will be completed by 08/31/2019. Administrator and Maintenance Director will review fire drill procedure with residents at August Resident council meeting.

Monitoring: Administrator or designee will monitor all fire drills going forward to ensure regulation 2600.132.h. is being met.

Legal Entity Representative

Signature

Amanda Gresh Administrator 8/16/19
Printed Name and Title Date

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141a - Medical Evaluation

Regulations

2600.

141. a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #1 was admitted to the home on 3/5/19, the residents DME does not indicate the date the resident was evaluated.

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.)

Action: Resident Services Director contacted physician to obtain an updated DME for resident #1. Attached is a copy of new DME. Administrator/Resident Services Director/designee will audit all current resident DMEs to ensure compliance with regulation 2600.141.a. This audit will be completed by 09/15/2019.

Training: Administrator/designee will train all staff involved in the admission process on regulation 2600.141.a. Training will be completed by 08/31/2019.

Monitoring: Administrator/designee will ensure all new resident admissions are compliant with regulation 2600.141.a.

Legal Entity Representative

Signature

Amanda Gresh Administrator 8/16/19
Printed Name and Title Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

141a 1-10 Medical Evaluation Information

Regulations

2600.

141a . A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #3's DME doesn't include the date the resident was evaluated on pg.1 or the resident's height.
Resident #2's DME dated 4/18/19 doesn't include weight, date of birth and body positioning.

REPEAT VIOLATION: 1/3/2019

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.)

Action: Effective day of inspection, 06/19/2019 Administrator/Resident Services Director/designee will begin to audit all current and new resident DMEs to ensure compliance with regulation 2600.141.a. This audit will be completed by 09/15/2019. The above listed resident #2 and resident #3 have since been discharged.
Training: Administrator/designee will train all staff involved in the admission process on regulation 2600.141.a. Training will be completed by 08/31/2019.

Legal Entity Representative

Amanda Gresh
Signature

Amanda Gresh Administrator 8/16/19
Printed Name and Title Date

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- ☐ Not Implemented

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

Resident #4's most recent DME was completed on 5/14/18.

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.)

Action: Resident Services Director contacted resident #4 physician to obtain an updated DME to include the above required information. Attached is a copy of the communication. Administrator/Resident Services Director/designee will audit all current resident DMEs to ensure compliance with regulation 2600.141.b.1. This audit will be completed by 09/15/2019.

Training: Administrator/designee will train all staff involved in the admission process on regulation 2600.141.b.1. Training will be completed by 08/31/2019.

Monitoring: Administrator/designee will ensure all new resident admissions are compliant with regulation 2600.141.b.1.

Legal Entity Representative

Signature

Amanda Gresh Administrator 8/16/19
Printed Name and Title Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

144c1 - Smoking Area Guidelines

Regulations

2600.

144c . A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

2 employees were observed smoking near the green fence that surrounds the dumpster of the home. The home is non-smoking.

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.)

Action: All facility staff were verbally educated day of inspection, 06/19/2019 on the home's non-smoking policy. No smoking policy will be reviewed with current staff at August staff meeting.

Training: Administrator will re-educate all staff on regulation 2600.144.c. Education will be completed by 08/31/2019.

Monitoring: Administrator will monitor facility property for smoking and take disciplinary action as necessary.

Legal Entity Representative

Signature

Amanda Gresh Administrator 8/16/19
Printed Name and Title Date

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- ☐ Not Implemented

183d - Prescription Current

Regulations

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

Description of Violation

On 6/19/19, Famotidine 20mg prescribed for individual resident #5, was in the home's medication cart; however, the medication was discontinued on 6/11/19.

On 6/19/19, Banophen 25mg prescribed for individual resident #4, was in the home's medication cart; however, the medication was discontinued on 5/14/19.

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.)

Action Resident #5 and #4's discontinued medications were removed and discarded day of inspection 06/19/2019. Medication cart audit was completed on 06/25/2019 to ensure all discontinued medications have been removed from carts.

Training: Resident Services Director/Administrator will re-educate all certified medication technicians on regulation 2600.183.d. Education will be completed by 08/31/2019.

Monitoring: Resident Service Director/designee will complete medication cart audits weekly and at monthly QA meeting to ensure compliance with regulation 2600.183.d.

Legal Entity Representative

Amanda Gresh
Signature

Amanda Gresh Administrator 8/16/19
Printed Name and Title Date

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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

Resident #3's Levemir flex pen was not dated when open.

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.)

Action: Resident #3's Levemir flex pen was disposed of day of inspection, 06/19/2019. A new LEVEMIR pen was opened and dated on 06/19/2019.

Training: Administrator/Resident Services Director will re-educate all certified medication technicians on regulation 2600.185.a. Education will be completed by 08/31/2019.

Monitoring: Administrator/designee will monitor medication carts through weekly audits to ensure compliance with regulation 2600.185.a.

Legal Entity Representative

Amanda Gresh — Signature

Amanda Gresh Administrator 8/16/19 — Printed Name and Title / Date

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225a - Assessment 15 Days

Regulations

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 #1 was admitted to the home on 3/5/19, the assessment portion of the RASP was not completed until 4/15/19.

Resident #2 was admitted to the home on 4/20/19, the assessment portion of the RASP was not completed until 5/6/19.

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.)

Action: Resident #1 and #2's resident assessment support plans were updated. Attached the residents updated resident assessment support plans as supporting documentation.

Training: Administrator/designee will train all staff involved in the admission process on regulation 2600.225.a. Training will be completed by 08/31/2019.

Monitoring: Administrator/designee will ensure all new resident admissions are compliant with regulation 2600.225.a.

Legal Entity Representative

Signature

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227a - Support Plan 30 Days

Regulations

2600.

227. a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted to the home on 3/5/19, the support plan portion of the RASP was not completed until 4/15/19.

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.)

Action: Resident #1 resident assessment support plan was updated. Attached is the level of care chart detail as supporting documentation.

Training: Administrator/designee will train all staff involved in the admission process on regulation 2600.227.a. Training will be completed by 08/31/2019.

Monitoring: Administrator/designee will ensure all new resident admissions are compliant with regulation 2600.227.a.

Legal Entity Representative

Amanda Gresh — Signature

Amanda Gresh Administrator — Printed Name and Title

8/16/19 — Date

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

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

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

Plan of correction implementation status as of 9-6-19 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ 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 #2's RASP dated 5/6/19 is not signed by the staff who participated in the development of the support plan including the resident.

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.)

Action: The most recent resident assessment support plan was obtained with signatures from all individuals who participated in the plan for resident #4, not resident #2. Resident #2 did not have a resident assessment support plan for the above stated date. An audit of all current residents RASP/Support Plan/LOC will be conducted to ensure all have appropriate signatures by 09/15/2019.

Training: Administrator/designee will train all staff involved in the assessment process on regulation 2600.227.g. Training will be completed by 08/31/2019.

Monitoring: Administrator/designee will ensure all new assessments are compliant with regulation 2600.227.g.

Legal Entity Representative

Amanda Gresh Administrator 8/16/19

Signature | Printed Name and Title | Date

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Plan of correction implementation status as of 9-6-19 (Date)

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

227h - Support Plan Refuse Sign

Regulations

2600.

227. h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #4's RASP dated 5/10/19 does not indicate the resident's refusal to participate or inability to participate in the development of 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.)

Action: Resident #4's RASP was updated to include resident's participation in the development of their support plan. Attached is the supporting documentation. An audit of all current residents RASP/Support Plan/LOC will be conducted to ensure all have appropriate signatures by 09/15/2019.

Training: Administrator/designee will train all staff involved in the assessment process on regulation 2600.227.h. Training will be completed by 08/31/2019.

Monitoring: Administrator/designee will ensure all new resident assessments are compliant with regulation 2600.227.h.

Legal Entity Representative

Amanda Gresh — Signature

Amanda Gresh Administrator — Printed Name and Title

8/16/19 — Date

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

Plan of correction implementation status as of 9-6-19 (Date)

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