pennsylvania
DEPARTMENT OF HUMAN SERVICES

November 26, 2019

Mr. Nathaniel D. Pace
Administrator
Morris-Pace Assisted Living, Inc.
416 Reading Avenue
West Reading, Pennsylvania 19611

RE: Morris-Pace Personal Care
License #: 215900

Dear Mr. Pace:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 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: *MORRIS-PACE PERSONAL CARE* **License Number:** *21590*
Address: *416 READING AVENUE,, WEST READING, PA 19611*
County: *BERKS* **Region:** *NORTHEAST*

Administrator

DRPACE61@gmail.com

Name: *Nathaniel Pace* **Phone:** *6103719590* **Email:** *DR.PACE61@GMAIL.COM*

No Period

Legal Entity

Name: *MORRIS-PACE ASSISTED LIVING INC*
Address: *416 READING AVENUE, WEST READING, PA, 19611*

Certificate(s) of Occupancy

Type: *Other* **Date:** *08/28/2007* **Issued By:** *Borough of Reading*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *59* **Waking Staff:** *44*

Inspection

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

Inspection Dates and Department Representative

07/18/2019 - On-Site: Gerald Dumas, Amy Deluca

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *63* **Residents Served:** *59*

Secured Dementia Care Unit

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

Hospice

Current Residents: *N.A.*

Number of Residents Who:

Receive Supplemental Security Income: *45*
Are 60 Years of Age or Older: *27*
Diagnosed with Mental Illness: *45*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *0*
Have Physical Disability: *0*

26b - Quality Management Plan Content

Regulations

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home's most recent quality management meeting minutes dated 10/23/2018 indicate that the following required topics were not discussed during the meeting: staff training and License Inspection Summary violations.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See P 1 of 7

Legal Entity Representative

N Pace — Signature

Nathaniel J Pace Admin 9/27/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 10-1-19 (Date)

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

Plan of correction implementation status as of 10-1-19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ 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:

Description of Violation

Direct care staff persons "A" , "B", "C" and "D" did not receive training in Emergency Preparedness Procedures in the training year 2018.

Repeat Violation 1/31/19

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 P 1 of 7

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Signature

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83b - Air Conditioner/Fans

Regulations

2600.
83.b. If a home does not provide air conditioning, fans shall be made available to residents when the indoor temperature exceeds 80°F.

Description of Violation

The temperature in bedroom H4 was 81.9° F at approximately 2:15pm. The home did not provide a fan to the resident and there was no air conditioner installed in the window.

Plan of Correction (POC)

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85e - Trash Outside Home

Regulations

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 10:05 a.m. during the initial physical plant walk through , two dumpsters located to the rear of the home, were observed open, thereby allowing for the penetration of insects and rodents.

Plan of Correction (POC)

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See P 2 of 7

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92 - Windows

Regulations

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

The exit doors in the L section and the J section were left wide open with no screen doors installed in either exit.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

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93a - Handrails

Regulations

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

The entrance door located on the inner side of the home where there are steps leading up to the home has an approximately 4 to 5 inch drop from the ground to the doorway. The home did not have a handrail or handle installed on the left side next to the door to assist with entry.

Plan of Correction (POC)

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See P 3 of 7

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96a - First Aid Kit

Regulations

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.

Description of Violation

The first aid kit located in the medication cart did not contain required scissors.

Plan of Correction (POC)

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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

The following food items were found in the home's kitchen stored without proper labeling to identify the contents: 1 gallon plastic container with a mayonnaise label contained milk but was not labeled as milk; 1 plastic container of flour was not labeled and dated; 1 plastic container of cream of wheat was not labeled and dated; 1 container of cereal stored in a plastic bag was not labeled and dated. There was also a sandwich found in a plastic bag in the refrigerator of section F that had no name, label, or date on it.

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 P 4 of 7

Legal Entity Representative

M Pace — Signature

Nathonie D Pace Admin 9/27/19 — Printed Name and Title / Date

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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

At approximately 10:00 a.m., the emergency exit doors "G" and "H were difficult to open with multiple attempts.

Repeat Violation 7/19/18

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.)

See P 4 of 7

Legal Entity Representative

Signature	Printed Name and Title	Date
N Pace	Nathaniel D Pace	9/27/19

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132b - Safety Inspection/Fire Drill

Regulations

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home did not have documentation that a fire drill was supervised by a fire safety expert in 2018. The home also did not have documentation that fire safety expert conducted a fire safety inspection in 2018.

Plan of Correction (POC)

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See P 4 of 7

The home's 132 b letter does reference the required observed fire drill but does not include the necessary fire safety inspection. The August 7, 2019 letter is incomplete and the fire safety inspection needs to be addressed as soon as possible. Upon completion, please send a copy to the Northeast Regional Office.
10-1-19 *ag*

Legal Entity Representative

Signature

Nathaniel Jack Admn 9/27/19
Printed Name and Title Date

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132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home did not have current documentation of a maximum safe evacuation time by a fire safety expert. On the following dates and times, the fire drill logs indicate the evacuation time exceeded 2 ½ minutes: 4/18/2019 at 11:15pm the evacuation time was 3 minutes and on 10/2/2018 at 05:35am the evacuation time was 2 minutes and 50 seconds.

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See P 5 of 7

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Nathanie L Pace Admin 9/27/19

Printed Name and Title Date

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133.1 - Exit Signs

Regulations

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word 'EXIT' in plain legible letters shall be placed at all exits.

Description of Violation

There is no exit sign over the dining room exit door . Exit signs direct residents, staff, and guests the direction to the closest exit out of the room and building in the event of a fire or emergency.

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 P 5 of 7

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Signature

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144c1 - Smoking Area Guidelines

Regulations

2600.
144.c. 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

There were 6 cigarette butts found in the grassy area and under bushes in the staff smoking area.

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 P 5 of 7

Legal Entity Representative

Signature

Nathaniel Pace Admn 9/27/19
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225c - Additional Assessment

Regulations

2600.
225.c. The resident shall have additional assessments as follows:

Description of Violation

The home did not complete a Resident Assessment and Support Plan (RASP) timely for resident #1. The most recent RASP was dated 5/20/2018.

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.)

See P 6 of 7

Legal Entity Representative

Signature

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9/27/19 — Date

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227d - Support Plan Medical/Dental

Regulations

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 # 2 exhibited behaviors such as paranoia about being poisoned by staff and hearing voices telling her to kill people as documented on an incident report dated 3/16/2019. The RASP dated 2/17/19 was not updated to reflect these behaviors. The RASP indicated there were no issues with hallucinations.

Plan of Correction (POC)

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See P 6 of 7

Legal Entity Representative

Signature	Printed Name and Title	Date
[signature]	Nathaniel J Pace Admr	9/27/19

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Inspection 7/18/19
Morris-Pace Personal Care

26-B

1. There are 5 items that must be present on the Quality Management/Minutes report. These items insure compliance and completion of our Quality Management appropriately.
2. I did not comply with the 5 required items needed for the QM minutes.
3. I completed the Quality Management/Minutes report and did not include all of the requiring items, Staff training & Licensing Inspection summary violations.
4. I have copied 26-B and attached it to my current QM/Minutes report to ensure that ALL ITEMS will be present on future QM/Minutes reports.
5. I will include the 5 items in all future QM/Minutes reports to be in compliance with 2600.26B.
6. I, the Admin. will be responsible to stay in compliance and will ensure that all 5 items are listed in the next QM/Minutes report. The Admin will complete QM/Minutes report in Oct. 2019 and all items on 26-B will be present to ensure our compliance. I have a copy of the regulation and the list to prevent future violations. 10-1-19 ag

65-G

1. In order to be in compliance with 2600, ALL STAFF must have training in the 13 items under 65-F & 65-G to ensure the safety and wellness of all residents.
2. During the trainings, I'm responsible to train on all of the required items and did not complete the training on Emergency Preparedness.
3. I, as the Admin. who does the training, did not have all of 65-G in the trainings in 2018, which is a violation. I have copied the regulation for the list of all required trainings to be completed and ensure compliance.
4. In my future trainings I have all of the 13 items listed in 65-F & G highlighted so I can stay in compliance and not repeat this violation.
5. During my future trainings I have all of the items needed for compliance and I will make sure that these 13 items are included in all future trainings for compliance.
6. I, the Admin. is responsible to fix this violation and also to ensure that it is not repeated, also responsible for monitoring and ensuring compliance of these regulations. 10-1-19 ag

83-B

1. The reason for this regulation is for the health and safety of all residents. Heat stroke can kill and resident's rooms need air circulation/fan/air conditioner for prevention of over heating.
2. Staff overlooked the fact that the air conditioner that was in that room wasn't there after the previous residents moved out.

3. Resident in H-4 did not have a fan/air conditioner and facility did not offer resident one. Resident's room had an air conditioner previously but the previous resident took it with him and we didn't notice this theft.
4. I purchased an air conditioner with the resident's funds; he now has the needed unit to be in compliant with this regulation. He will keep this unit in his room so this won't happen again, also, if/when this resident relocates M-P will be mindful of the need for a new unit/fan for the next resident.
5. Our maintenance person (Derek) is responsible for making sure all rooms have either a fan or air conditioner present in resident's rooms and operational. He is also responsible for informing the Admin. if there are not any, and then the Admin will purchase one. I, the Admin. is responsible for monitoring.
6. The Admin is responsible for compliance with assistance from our maintenance person and other staff, informing the Admin. when they are cleaning residents rooms. If the unit/fan is missing the staff are required to notify Admin. for compliance. 10-1-19 ag

85-E

1. In order to keep pest/rodents from infiltrating the facility all trash containers must be covered, including the dumpsters in the back of the facility.
2. Lids to our dumpsters were open, allowing rodents/insects to penetrate.
3. When the dumpsters were emptied, our collection company leaves the lids open and lid are caught in between the front and back dumpsters when they are finished, causing this violation. Also, making it difficult for staff to close the lids due to the weight of the dumpsters. Inspectors found the dumpsters lid open, it is supposed to be closed at all times.
4. Admin. called MASCARO collection company informing them of our issue and was promised that they will, moving forward making sure that the lids are closed and not caught between the dumpsters, also staff has been informed to close/cover all trash containers to prevent excessive pest/rodents from facility.
5. Kitchen staff will monitor the dumpsters daily to ensure that they are covered and the facility is in compliance, also the PCA's/Live-ins, & other staff will also monitor dumpsters and trash cans when they're removing trash from facility.
6. ALL STAFF, including Admin. are responsible to keep our trash cans/dumpsters covered. Admin. will be monitoring for compliance, doing periodic checks during the day. 10-1-19 ag

92

1. Any open doors/windows without screens allows pest/rodents into the facility and that compromises the health and safety of the residents.
2. M-P has excessive flooding from the previous nights rain in our 2 doorways and I (Admin) opened the doors for airing/drying out. The interior doors with access to the facility were closed/locked to help prevent anyone or rodents from entering.
3. Due to the flooding from the excessive rain the night before, two of our doorways were flooded and the doors were open for the floors/carpet to dry out. Even though all the other entrances were closed in that area to prevent pest/rodents from entering the main facility, we were still cited, which I feel is unfair. I have

to dry out the areas to prevent mold & mildew from taking hold and affecting my resident's health.

4. Once the flooring had dried out, the doors where sealed to prevent any pest/rodents from entering the building.
5. I'm at a loss, I have to air out the flooding areas to prevent mold/mildew from growing and a fan didn't work fast enough like the warm air from outside. It's not feasible to install a screen and I do not leave the exit doors open for any other reason other than to dry the affected areas.
6. The doors were closed before the inspector left because the flooring was dry and the maintenance man checked on the flooring and the doors hourly. The responsibility of ensuring/preventing future violations is the maintenance man and myself the Admin. Admin is ultimately responsible for compliance.

10-1-19 ag

The Administrator will try a combination of wet vac and dehumidifier next time this happens.

93-A

1. The regulation is important to give the resident's any support needed when coming into the facility where there's a step or steps.
2. No railing/hand bar was present for usage upon entering/stepping into the facility.
3. On the other side of the facility there is an entrance with steps and there was NOT a hand railing to assist the residents when they are entering that side of the building as they step into facility.
4. That next day our maintenance man installed the hand bar-railing for compliance.
5. Once the railing is installed, it is permanent. It will not be removed. The maintenance man is responsible to install and maintain this hand bar/railing.
6. The maintenance man & I will monitor the railing to ensure that it stays put. We can see that railing/hand bar from my office and will do periodic checks/maintenance to prevent future violations. Admin is responsible for compliance.

10-1-19 ag

96-A

1. Personal Care Homes must have a first aid kit for the safety and welfare and to address the needs of any medical problem.
2. Staff used the scissors in first-aid kit and did not replace them.
3. When the new first aid kit replaced the old one, new one was placed in the Med Cart without the scissors, staff removed the scissors from old kit and did not replace in the new kit.
4. During the inspection my staff replaced the scissors and we tied up the bag that's holds the first aid kit, keeping all of the items in the first-aid kit secure and present.
5. Each week when I audit the Med Cart I will be checking to ensure that all items are in place. I have my checklist from the regulations on Med Cart to compare.
6. It is my, Admin., responsibility to stay in compliance, which will be done on a weekly basis while I'm auditing the Med Cart. Also, Med staff will be doing periodic checks to confirm that all items are present and accounted for.

Please keep in mind the First Aid Kit items must be portable to meet the needs of the resident where the emergency is. 10-1-19

103-E

ag

103E

1. All food must be dated for freshness and labeled to ensure what it is in the container. Food allergies and mishaps can occur when no label or date is present and can cause harm to residents.
2. Containers that we used were not dated or labeled.
3. We had a container of Milk in a Mayo labeled container, flour container, & containers of hot & cold cereal that did not have a date or label on it.
4. While the inspectors were here Sam, our Dietary Dir labeled and dated all containers. Sam & kitchen staff are responsible for making sure that all foods are labeled & dated.
5. Sam, Jean, & the live-in staff that do breakfast will make daily checks while in the kitchen to ensure compliance. It is their responsibility to stay compliant.
6. Weekly, when Sam & Jean are cooking they will be monitoring the containers in the kitchen and replacing any that have fallen off or washed off.
7. The Dietary Dir & kitchen staff are responsible for and preventing future violations by overseeing this regulation and keeping the kitchen compliant.

10-1-19 ag

121-A

1. Doors shall be easily opened and exited with out any interference/blockage.
2. 2 exit door frames were swelled and difficult to open.
3. Due to the overwhelming rain, the wood around the doors and the doors swelled causing the opening and exiting difficult to open and close.
4. The maintenance man has sanded the doors and the framing to loosen the tightness so that the doors open and close with ease.
5. M-P is in the middle of replacing the doors in the facility, they are old and need replacing. The Borough is coming out 8/6/19 along with the contractor to apply for the permit and get started on ordering the doors. (see attached) New doors & frames should be completed by 10/31/19.
6. Once the new doors are installed there won't be any reason for the door to stick and they will have new framing to prevent the swelling. The Admin & maintenance man are responsible for correcting, monitoring, & inspecting the doors to ensure that they all free opening and closing. Ultimately the Admin is responsible.

10-1-19 ag

132-B

1. PCH's are responsible for having a Fire Safety Inspector draw up a letter from our local Fire Dept. showing that a unannounced fire drill was performed and the time allow by them for evacuation.
2. No unannounced drill nor letter of time to evacuate were completed in 2018.
3. W. Reading Fire Dept did not come out. I was told by the Fire Dept Capt. that other homes complained that it was inconvenient and they, the Fire Dept. stopped doing them. I wasn't aware because it's usually done when I'm not in the building. Fire Capt. Mark Burkholder informed me that he will get this done ASAP. (see attached letter)

4. Fire Dept Capt. has scheduled a visit, unannounced, and once that's done he will complete the needed letter. (see attached, unannounced drill was completed)
5. I have added a request on/with my annual letter to the Fire Capt. that the DHS document be completed and forwarded to me, after drill is completed, for compliance.
6. As the Admin I am responsible for making sure that this is done. I will be communicating with the Fire Capt. in January to ensure compliance that our drill is on their calendar.

10-1-19 ag

132-D

1. Fire Safety inspectors must complete a drill & determine what is a good evacuation time for our personal care home, this enables the staff to know and act accordingly on that time.
2. Unannounced drill by Fire Capt was not completed in 2018.
3. Fire Capt did not complete the unannounced drill which meant that the evacuation letter that determines the time was not completed in our calendar year.
4. I contacted the Fire Capt on the day of our inspection and he informed me that he will schedule a unannounced drill ASAP. I also have a letter that will be mailed, it is requesting that they forward me the DHS document which states that the drill was done and what our evacuation time is.
5. I have added to my letter to the Fire Capt that I will need the letter from him and the evacuation time to keep us in compliance.
6. I have attached the revised letter for the Fire Capt to keep him aware of our needs to fix the problem. Admin is responsible for compliance, I will be sending this letter out in the beginning of the year and will contact the Fire Capt some time in June of that year to prevent another violation. 10-1-19 ag

133.1

1. Exit signs MUST be posted to ensure proper evacuation routes for residents, staff, & guests.
2. There were no exit signs on kitchen exit door.
3. Kitchen exit door was replaced and the required "EXIT" sign was not place on the door to show evacuation route from dining room.
4. I purchased several "exit signs", they were placed on all of the doors that exited the facility that did not have them posted, this way all evacuation routes are easily available.
5. Maintenance man has a check list to follow, on this list is to check he is required to make sure that the exit signs are visible and intact.
6. Admin., maintenance man, & all staff are responsible for informing myself or Derek that a sign is missing or not posted, this way we can prevent future violations. 10-1-19 ag

144-C

1. Fire receptacles must be in place where smoking is allowed. This will help prevent fires from starting and help the safety of residents.

2. Cigarette butts were found in the bush bed.
3. Cigarette butts were found in the bush bed in the back of the facility where the staff is allowed to smoke.
4. Staff went through the beds of bushes and picked up all of the butts. This area is a walkway for pedestrians also, they use this walkway to keep them safe from the driveway on the other side.
5. I will have staff randomly check the beds for butts during each week to ensure compliance. I will have a form for staff to initial that the beds were checked daily and cleaned when necessary. (see attached form)
6. Admin is responsible for compliance. Dietary Director will be monitoring the check list daily to ensure that staff is doing their due diligence. The check list is located on the exit door from kitchen near the bush beds. 10-1-19 ag

225-C

1. The resident shall have their annually assessment (RASP) done and available to DHS upon request.
2. Records staff did not print out new RASP, so it was emailed to me.
3. Inspector requested the RASP for resident and it was not present in the facility.
4. I called the records guy during our inspection and he emailed the RASP to me, he did not print out the RASP when he was here assessing her.
5. The new RASP was printed and signed 7/18/19, same day as my inspection. I spoke to my records keeper about this continual problem.
6. I have instituted a plan where my Dietary Dir goes through every chart and give me (Admin) the written info on the charts, dates, and expirations to stay ahead of these issues. It's gotten a lot better due to our current plan. Admin is responsible for compliance, I will continue our plan in having 3 (Admin., Dietary Dir., & record keeper) set of eyes on the RASP & DME to ensure that we will stay compliant. 10-1-19 ag

227-D

1. Resident's records are to be completed/updated in a timely fashion in order to keep up with the needs of resident.
2. RASP wasn't updated in a timely fashion of the residents paranoia.
3. A resident was having hallucinations and was hospitalized in order to assist her with this issue to meet her needs, however, her RASP was not updated to reflect the change in her needs.
4. I updated her RASP to reflect the change in needs. I am responsible for not following the protocol once an incident report has been completed, forwarding the change into her chart with the copy of the incident.
5. I, as the Admin will have a separate training on the forwarding of important changes into the RASP, this way all staff who fill out the incident reports will take the time to complete the RASP as well. This will keep us compliant.
6. ALL STAFF are responsible to make sure that all significant changes are transferred onto the RASP. We have been making a copy of the incident report and keeping one for the communication book, we will look over each report

weekly to make sure that changes are reported on RASP, this will help us stay compliant. I, as the Admin. carry the responsibility of making this happen, preventing future violations, and staying on top of reporting changes to the RASP. Friday is a good day to pull the information book and check that charts for compliance.

10-1-19 ag