



January 22, 2020

Mr. Dennis W. Nebel, Psy.D.
Executive Director
Westfield Behavioral Health Affiliates, Inc.
130 West North Street
New Castle, Pennsylvania 16101

RE: Westfield
5826 Old Pulaski Road
New Wilmington, Pennsylvania 16142
Certificate #: 474240

Dear Mr. Nebel:

As a result of the Department's Bureau of Human Services Licensing annual inspection on September 6, 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,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written over a white background.

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

RECEIVED

12/3/19

Western Region Field Office
Bureau of Human Services Licensing**Violation Report****Facility Information**Name: *WESTFIELD*License Number: *47424*Address: *5826 OLD PULASKI ROAD,, NEW WILMINGTON, PA 16142*County: *LAWRENCE*Region: *WESTERN***Administrator**Name: *Jamie Cochran*Phone: *7246583006*Email: *jcochran@humanservicescenter.net***Legal Entity**Name: *WESTFIELD BEHAVIORAL HEALTH AFFILIATES INC*Address: *130 WEST NORTH STREET, NEW CASTLE, PA, 16101***Certificate(s) of Occupancy**Type: *C-3 SP*Date: *12/13/1996*Issued By: *L&I***Staffing Hours**Resident Support Staff: *0*Total Daily Staff: *8*Waking Staff: *6***Inspection**Type: *Full*

BHA Docket #:

Notice: *Unannounced*Reason: *Renewal***Inspection Dates and Department Representative***09/06/2019 - On-Site: Joe Eveses, Lori Gillette***Resident Demographic Data as of Inspection Dates****General Information**License Capacity: *8*Residents Served: *8***Secured Dementia Care Unit**In Home: *No*

Area:

Capacity:

Residents Served:

HospiceCurrent Residents: *0***Number of Residents Who:**Receive Supplemental Security Income: *8*Are 60 Years of Age or Older: *4*Diagnosed with Mental Illness: *8*Diagnosed with Intellectual Disability: *1*Have Mobility Need: *0*Have Physical Disability: *0*

65f - Training Topics

DEC 03 2019

Regulations

WESTFIELD POLICE
Municipal Building, 1000 Main St., Westfield, MA 01097

2600.

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

- 3. Care for residents with dementia and cognitive impairments.
- 6. Safe management techniques.
- 7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff A, hired 12/11/06, did not receive training in the following training topics during the 1/1/18 - 12/31/18 training year:

Care for residents with dementia and cognitive impairment, Safe management techniques, and Care for residents with mental illness or intellectual disabilities

Direct care staff B, hired 12/11/17, did not receive training in the following training topics during the 1/1/18 - 12/31/18 training year:

Care for residents with dementia and cognitive impairment, Safe management techniques, and Care for residents with mental illness or intellectual disabilities

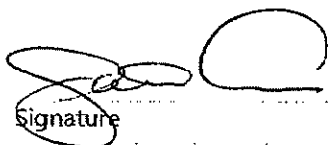
Repeat Violation: 8/10/18

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 page 2A of 13

Legal Entity Representative


Signature

Jessie Cochran PCH Administrator 12/3/19
Printed Name and Title Date

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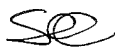
The above plan of correction is approved as of

1/13/20
(Date)

Plan of correction implementation status as of

1/13/20
(Date)

The above plan of correction was approved by


(Initials)

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

2600.65 f

1. Corrective Action: Staff person A hired 12/11/06 had training for Care For resident with dementia and cognitive impairments; safe crisis management techniques, care for residents with mental illness and intellectual disabilities on 3/14/18. See attached Staff meeting documents. The sign in sheets did not include all of the topics at the time of the inspection.

Staff person B had the training as well as indicated by the sign in sheets for the staff meeting on the 3/14/18.

Monitoring: I will revise the sign in sheets to list all of the topics as described in the PA Code 2600.65 f.

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WEST REGION FIELD OFFICE
Human Services Learning

Within 30 days of receipt of the plan of correction: The administrator shall develop and implement policy and procedures to ensure all direct care staff persons receive training in all topics, in accordance with §2600.65(f)(1-7) during the training year. All staff involved in providing training shall be educated on the new policy and procedures. Documentation of education shall be kept.

SE 1/13/20

Within 30 days of receipt of the plan of correction: The administrator shall audit all staff records to ensure that during the 2019 training year, all direct care staff received training in all topics, in accordance with §2600.65(f)(1-7). Any missing trainings shall immediately be completed. Documentation of the audit shall be kept and reviewed at the next Quality Management Meeting.

SE 1/13/20

DEC 03 2019

WEST REGIONAL OFFICE
Human Services Licensing

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Direct care staff A, hired 12/11/06, did not receive training in the following training topics during the 1/1/18 - 12/31/18 training year:

- *Fire safety training by a fire safety expert
- *Emergency preparedness

Direct care staff B, hired 12/11/17, did not receive training in the following training topics during the 1/1/18 - 12/31/18 training year:

- *Fire safety training by a fire safety expert
- *Emergency preparedness

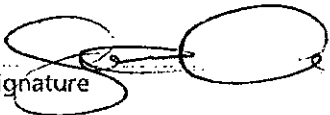
Repeat Violation: 8/10/18

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.)

Legal Entity Representative

See page 3A of 13

Signature 

JAMIE COCHRAN PCH Administrator 12-31-19
Printed Name and Title Date

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


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(Date)

1/13/20
(Date)

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(Date)

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2600.65 g

2. Corrective Action:

Staff were not trained during the 1/1/18 thru 12/31/18 calendar year due to a change in personnel at the local fire department. Westfield staff were not able to contact the fire safety expert until January of 2019. Training was held on 1/23/19.

Staff person A hired 12/11/06 was trained in Fire safety by a fire safety expert to include emergency preparedness on 1/23/19. Documentation attached.

Staff person B hired 12/11/17 was trained in Fire Safety by a fire safety expert to include emergency preparedness on 1/23/19. Documentation attached.

Monitoring: I will contact the local fire department ahead of the end of the calendar year to schedule training for the next training year. I will request notification of any changes in the event that the department is unable to follow thru on the training date in a timely fashion in order for me to make arrangements with an alternative department.

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DEC 03 2019

WEST REGION FIELD OFFICE
Human Services Licensing

Within 30 days of receipt of the plan of correction: The administrator shall develop and implement policy and procedures to ensure all direct care staff persons receive training in all topics, in accordance with §2600.65(g)(1-5) during the training year. All staff involved in providing training shall be educated on the new policy and procedures. Documentation of education shall be kept.

SE 1/13/20

Within 30 days of receipt of the plan of correction: The administrator shall audit all staff records to ensure that during the 2019 training year, all direct care staff received training in all topics, in accordance with §2600.65(g)(1-5). Any missing trainings shall immediately be completed. Documentation of the audit shall be kept and reviewed at the next Quality Management Meeting.

SE 1/13/20

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DEC 03 2019

WESTFIELD FOOD SERVICE
Outdated Food Inspection

103i - Outdated Food

Regulations

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

Multiple expired foods were in the home's kitchen refrigerator to include:

- *Three plastic bags of American cheese with an expiration date of 4/4/19
- *A plastic bag containing 1/2 pound of hard salami with a best used date of 8/31/19
- *An opened, 1/2 gallon container of orange juice with a best used date of 8/19/19

Multiple expired foods were in the home's kitchen freezer to include:

- *A box of taco shells with a use by date of 7/13/17
- *A box of lasagna noodles in a plastic bag with a use by date of 3/18/15
- *2 macaroni and cheese cups with a use by date of 10/29/17


Repeat Violation: 8/10/18

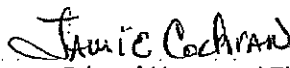
Plan of Correction (POC)

(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.)

Legal Entity Representative

See page 4A of 13

Signature 

 PCH Administrator 12-3-19
Printed Name and Title Date

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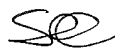
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(Date)

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(Date)

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- Not Implemented

2600/103i

3. Corrective Action:

3 bags of American cheese dated 4/4/19 and a plastic bag of hard salami with a date of best used by 8/31/19 were in the refrigerator on the date of the inspection 9/6/19. The items had been purchased and placed in the freezer with a date recorded of the date purchased and put in the freezer. At the time of inspection we did not have the date that the cheese and meat was taken out of the freezer resulting in a violation.

Boxes of taco shells, lasagna noodles and macaroni and cheese identified as outdated were discarded along with the aforementioned items were discarded at the time of inspection.

Monitoring:

I have assigned the midnight shift to inspect the freezer and cupboards for outdated foods and discard items that are outdated weekly. I will check weekly to make certain that this has been done.

I have instructed the staff to date food going into the freezer and once again upon taking it out of the freezer. I understand that cheese can be frozen for up to 8 months and deli meats up to 3 months.

Documentation of inspections shall be kept.

 1/13/20

RECEIVED
DEC 03 2019
WEST REGIONAL OFFICE
HUMAN RESOURCES DIVISION

DEC 03 2019

WESTFIELD POLICE OFFICE
POLICE TRAINING

109b - Rabies Vaccination

Regulations

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

2 cats reside in the home; however, the home has no certification of rabies vaccination for either cat.

Repeat Violation: 8/10/19

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.)

Legal Entity Representative

See page 5A of 13

Signature 


Jamie Cochran
Printed Name and Title

PC.H Administrator 12.3.19
Date

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(Date)

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2600.109b.

Corrective Action:

At the time of inspection, the cats on the premises did not have current rabies vaccination record. I took the cat to Caritas's Kennel. An appointment has been scheduled on 12/03/19 to be immunized. Record will be forward to the Department of Human Services upon completion. The cats will remain in the kennel until vaccination have occurred.

Monitoring:

Prior to the expiration date on the vaccination I will have the animals seen by the vet.

Within 15 days of receipt of the plan of correction: The administrator shall develop and implement policy and procedures to ensure all cats and dogs present at the home have a current rabies vaccination.

SE 1/13/20

Within 30 days of receipt of the plan of correction: The administrator shall audit all pet files to ensure each file contains a current rabies vaccination from a licensed veterinarian. Any pets with missing or expired rabies certificates shall immediately receive a rabies vaccination from a licensed veterinarian and the certificate of vaccination shall be kept. Documentation of the audit shall be kept and reviewed at the next Quality Management meeting.

SE 1/13/20

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JAN 13 2020
WEST REGION CASES / OFFICE
HUMAN SERVICES LICENSING

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DEC 03 2019

WESTFIELD POLICE DEPARTMENT
COMMUNITY POLICE

130h - Inoperable Smoke Detector

Regulations

2600.

130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

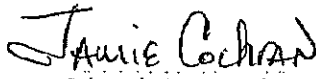
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Legal Entity Representative

See page 6A of 13


Signature

 PCH administrator 12.3.19
Printed Name and Title Date

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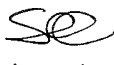
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2600.130.h

Corrective Action:

At the time of inspection, the emergency procedures did not indicate the procedures that will be implemented until a faulty fire detector or alarm is operable. I have updated the Policy and all staff made aware of the protocol. Please see the attachment.

Monitoring:

I have become familiar with 2600.130 and will train staff on the content annually. I will inspect to make certain policies are up to date and update in accordance with DHS regulations.

RECEIVED

DEC 03 2019

WEST VIRGINIA FIELD OFFICE
Citizen Services Advising

RECEIVED

WESTFIELD

DEC 03 2019

47424

WESTFIELD FIRE DEPARTMENT
100 Main Street, Westfield, MA 01097

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 most recent fire safety inspection conducted by a fire safety expert was on 1/23/19. However, the previous inspection was conducted on 11/16/17.

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.)

Legal Entity Representative

See page 7A of 13

Signature 

Jamie Cochran PE# Administrator
Printed Name and Title

12.3.19
Date

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

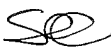
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RECEIVED

DEC 03 2019

WEST REGION FIELD OFFICE
(Human Services Library)**2600.132b.****Corrective Action:**

At the time prior to the inspection there were no available fire safety experts in the area to provide the training due to staff changes in the fire department. I contacted the fire department to provide the training. They provided the training at their earliest date of 1/23/19. All staff were trained on fire safety inspection and fire drill was conducted on the 1/23/19 date by the fire safety expert.

Monitoring: I will contact the local fire department ahead of the end of the calendar year to schedule training for the next training year. I will request notification of any changes in the event that the department is unable to follow thru on the training date in a timely fashion in order for me to make arrangements with an alternative department.

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132e - Fire Drill Sleeping Hours

DEC 08 2019

WESTFIELD FIELD OFFICE
SOUTH WINDSOR LICENSING

Regulations

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 5/29/19 at 5:45 a.m. The previous sleeping hours fire drill was conducted on 8/14/18 at 4:30 a.m.

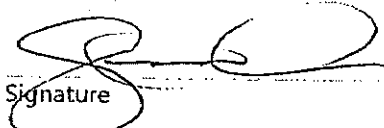
Repeat Violation: 8/10/18

Plan of Correction (POC)

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Legal Entity Representative

See page 8A of 13


Signature

Jamie Cochran PCH administrator 12.3.19
Printed Name and Title Date

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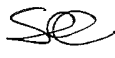
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DEC 03 2019

VICENT REGIONAL FIRE OFFICE
COUNCIL SERVICES DEPARTMENT


2600.132e

Corrective Action: At the time of inspection the fire drill record indicated that there was 1 fire drill documented during the sleeping hours instead of 1 every 6 months during sleeping hours. On 8/14/18 at 4:30 am I conducted a fire drill. See attached.

Education: In a staff meeting 8/15/18 staff were informed the importance of conducting fire drills at least 1 time every 6 months. When conducting fire drills staff should document the date, time, whether it was AM or PM, the duration of the drill, all staff and residents participating and any concerns that may have occurred during the drill.

Monitoring: I will conduct or have conducted unannounced fire drills to occur in accordance with DHS regulations. A record will be maintained to include dates of fire drills, times and duration of drills, the number of residents and staff participating. This record will include any problems occurring with the evacuation or equipment. I will review the record at the end of each month to determine if fire drills have been completed.

Immediately, then at least monthly, the administrator shall monitor the home's fire drill record to ensure a fire drill is held at least once per month and a sleeping time fire drill is held at least once every six months. All fire drills shall be unannounced to staff and residents, held on different days of the week, and at different times of the day and night in accordance with 2600.132(a), 2600.132(e) and 2600.132(g). Documentation of fire drills shall be kept in accordance with 2600.132(e).



1/13/20

RECEIVED

DEC 03 2019

WESTFIELD POLICE OFFICE
CLERK (LAW ENFORCEMENT)

141b1 - Annual Medical Evaluation

Regulations

2600.

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

Description of Violation

Resident #1's annual medical evaluation, dated 9/3/19, was incomplete. The following sections were blank:

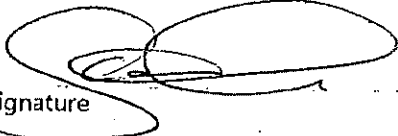
- 4 - Special health or dietary needs
- 8 - body positioning/movement
- 10 - mobility needs assessment

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.)

Legal Entity Representative

See page 9A of 13

Signature 

Janie Cochran PCH administrator 12-31-19
Printed Name and Title Date

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

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(Date)

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2600.141. b1

Corrective Action: A resident shall have a medical evaluation at least annually. Resident A had just been to the physician and his DME was incomplete for 9/3/19. This record has been updated to include a check in the special dietary needs section. In this case there are none. Additionally there are no needs for body positioning and movement or mobility. Please see the attached.

Monitoring: I will inspect and make sure DME's are completed annually prior to including them into the resident PCH file.

Within 30 days of receipt of the plan of correction and at least monthly thereafter: The administrator or designated staff person shall audit all resident records to ensure an in-person medical evaluation has been completed within the past year. The audit shall also include ensuring all required information is accurate and complete. Missing or incomplete medical evaluations shall immediately be returned to the physician for completion or new medical evaluations shall be scheduled. Documentation of the audits shall be kept.

SE 1/13/20

DEC 03 2019
WEST VIRGINIA HEALTH SERVICES LICENSING

DEC 03 2019

162c - Menus Posted

Regulations

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

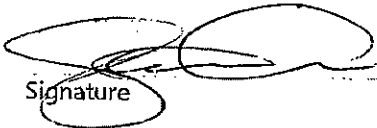
On 9/6/19, menus for the week of 9/1/19 - 9/7/19 and 9/8/19 - 9/14/19 should have been posted. However, the only menu posted was for the week of 8/18/19 - 8/24/19.

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.)

Legal Entity Representative

See page 10A of 13


Signature

JAMIE COCHRAN POH administrator 12.3.19
Printed Name and Title Date

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1/13/20
(Date)

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SC
(Initials)

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1600.162c.

Corrective Action: At the time of the inspection menus should have been posted for the current 2 week period. We had a menu posted for the week of 8/18-8/24/19. I had a menu in my office that should have been posted on the refrigerator for the respective date. We had gotten a new refrigerator and the menu had not made it to the refrigerator to be posted.

Education: I informed staff on 9/16/19 that menus should be current and posted for the current 2 week period.

Monitoring: All staff will share responsibility of making sure the menus are current and posted as specified in the regulation 162c. I will review them weekly.

Documentation of weekly reviews shall be kept.

SE 1/13/20

RECEIVED

DEC 08 2019

WEST VIRGINIA STATE UNIVERSITY
OFFICE OF THE SUPERVISOR OF HEALTH SERVICES

184a - Labeling OTC/CAM

DEC 03 2019

Regulations

WESTFIELD POLICE OFFICE
POLICE DEPARTMENT

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.

Description of Violation

Resident #2 is prescribed Lamotrigine 100mg – take one half tab (50mg) by mouth twice a day. However, the pharmacy label indicates – Lamotrigine 25mg – take 2 tabs (50mg) by mouth twice a day.

Repeat Violation: 8/10/18

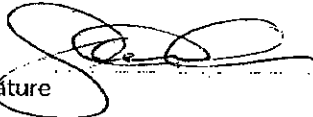
Plan of Correction (POC)

(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.)

Legal Entity Representative

See page 11A of 13

Signature



Jamie Cochran POH administrator

Printed Name and Title

12-3-19
Date

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

The above plan of correction is approved as of

1/13/20
(Date)

Plan of correction implementation status as of

1/13/20
(Date)

The above plan of correction was approved by

SC
(Initials)

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

RECEIVED

DEC 08 2019

MINNESOTA DEPARTMENT OF HEALTH
COMMUNITY CARE LICENSING

2600.184.a

Corrective Action: At the time of the inspection we had changed the pharmacy we had been using. The pharmacy had packaged Resident #2 medication in Lamotrigine (2) 25 mg tabs which would be 50 mg twice a day. The physician had ordered one half tab of Lamotrigine 100 mg. I contacted the pharmacy to have them re-package to one half of a 100mg tab to take twice per day.

Education: I informed staff to inspect medications upon receipt from pharmacy for accuracy and in compliance with physician's orders.

Monitoring: I will follow-up with staff after the PCH receives medications for the week to determine any discrepancies or problems correcting them in a timely fashion.

Immediately, then at least monthly, a designated staff person qualified to administer medications shall audit prescription medications to ensure they are stored in their original container and labeled with a pharmacy label in accordance with 2600.184a. The pharmacy label and the MAR shall be compared to the prescriber's order. Any discrepancies discovered shall be verified with the prescriber and immediately corrected. Documentation of audits shall be kept.



1/13/20

225a - Assessment 15 Days

DEC 08 2019

Regulations

ALCOHOL, TOBACCO AND FIREARMS
DEPARTMENT (A.T.F.)

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

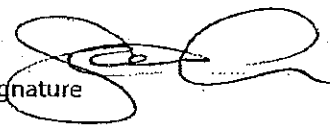
Resident #3's initial assessment, dated 3/15/19, does not indicate the resident's ability to use and avoid poisonous materials. This section is blank.

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.)

Legal Entity Representative

See page 12A of 13

Signature 


Jamie Cochran POH administrator
Printed Name and Title

12/3/19
Date

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(Date)

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(Date)

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(Initials)

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- Not Implemented

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DEC 03 2019

WEST VIRGINIA FIELD OFFICE
COMMUNITY SERVICES DIVISION

2600.225a.

Corrective Action: At the time of the inspection Resident #3's initial assessment was incomplete. I had inadvertently left blank the box indicating the residents' ability to use and/or avoid poisonous materials. This record has been updated. Please see attached.

Monitoring: In the future, when completing the initial assessment I will make sure each box is checked and if interventions are needed to have them included prior to placing the document in the residents' PCH file.

Within 30 days of receipt of the plan of correction: The administrator or designated staff person shall audit all resident records to ensure a current assessment is completed, accurate and present in each resident's record. Documentation of the audit shall be kept.

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225c - Additional Assessment

Regulations

2600.

- 225.c. The resident shall have additional assessments as follows:
 1. Annually.

WESTFIELD POLICE OFFICE
Community Services Licensing

Description of Violation

Resident #2's most recent assessment, dated 10/23/18, does not include the diagnosis of depression, bi-polar disorder, high blood pressure and asthma, as indicated on his most recent medical evaluation, dated 10/23/18.

Repeat Violation: 8/10/18

Plan of Correction (POC)

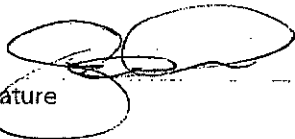
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

SE 1/13/20

Legal Entity Representative

See page 13A of 13

Signature



JAMIE COCHRAN PCH administrator 12.7.19
Printed Name and Title Date

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The above plan of correction is approved as of

1/13/20
(Date)

Plan of correction implementation status as of

1/13/20
(Date)

The above plan of correction was approved by

SE
(Initials)

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

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DEC 08 2019

WESTERN STATE UNIVERSITY
CLERK OF COURTS

2600.225c

Corrective Action: At the time of inspection Resident #2's assessment dated 10/23/18 did not include the following dx: depression, bipolar disorder, high blood pressure and asthma. These diagnoses were identified on the medical evaluation dated 10/23/18. The assessment has been updated for the plan of correction to include the diagnoses of depression, bipolar disorder, high blood depression and asthma.

Monitoring: In the future, when completing the assessment I will make sure all boxes are clearly marked and all diagnoses that are on a medical evaluation are included in the assessment prior to placing the record in the PCH File.

Within 30 days of receipt of the plan of correction: The administrator or designated staff person shall audit all resident records to ensure a current assessment is completed, accurate and present in each resident's record. Documentation of the audit shall be kept.

 1/13/20