



Sent via e-mail: mmclaughlin@wrc.org
rmcconnell@wrc.org

MAILING DATE: January 9, 2020

Ms. Barbara Sepich
President/CEO
WRC Pennsylvania Memorial Home
985 Route 28
Brookville, Pennsylvania 15825

RE: Highland Oaks at Water Run
300 Water Run Road
Clarion, Pennsylvania 16214
Certificate #: 447680

Dear Ms. Sepich:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on October 8, 2019, found violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The enclosed Licensing Inspection Summary (LIS) specifies the violations.

On November 26, 2019 and December 13, 2019 via email we requested that you complete a plan to correct the violations. On December 16, 2019, we called you requesting an acceptable plan of correction; to date, we have not received an acceptable plan to correct the violations. Therefore, we have attached a directed plan to correct the violations.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with Choose an item., must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you have any questions, please contact me at 412-509-0686.

Sincerely,

A handwritten signature in black ink that reads "Jody Garvey".

Jody Garvey
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

WEST REGION FIELD OFFICE
BUREAU OF HUMAN SERVICES LICENSING
License Number: 44768

Facility Information

Name: *HIGHLAND OAKS AT WATER RUN*
Address: *300 WATER RUN ROAD,, CLARION, PA 16214*
County: *CLARION* Region: *WESTERN*

Administrator

Name: *Michelle McLaughlin* Phone: *8142263799* Email: *BSEPICH@WRC.ORG*

Legal Entity

Name: *WRC PENNSYLVANIA MEMORIAL HOME*
Address: *985 ROUTE 28, BROOKVILLE, PA, 15825*

Certificate(s) of Occupancy

Type: *Other* Date: *05/26/2016* Issued By: *Monroe Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *63* Waking Staff: *47*

Inspection

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

Inspection Dates and Department Representative

10/08/2019 - On-Site: Laurie Garrigan, Belinda Graziano, Michael Morini, Jody Garvey

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* Residents Served: *46*

Secured Dementia Care Unit

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

Hospice

Current Residents: *46*

Number of Residents Who:

Receive Supplemental Security Income: *2* Are 60 Years of Age or Older: *46*
Diagnosed with Mental Illness: *23* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *17* Have Physical Disability: *2*

FILED

DEC 17 2019

ADULT REGIONAL OFFICE
10000 ...

17 - Record Confidentiality

Regulations

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At approximately 10:00 a.m., the privacy coding document was attached to the Licensing Inspection Summary, dated 7/19/19, that was posted in the home and the privacy coding included resident #1's name.

At 2:35 p.m., the private information of multiple residents was unlocked, unattended and accessible at the 2nd floor nurses' station to include:

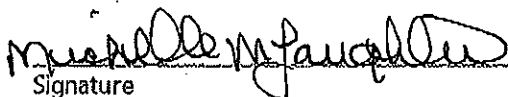
- *The 2nd floor communication log documenting resident #2's need for two hour incontinence checks as well as multiple other resident's care needs.
- *The 2nd floor shift duty binder with residents #2 and #3's meal assistance and mobility needs.
- *Resident #3's fall prevention plan with daily notes on 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.)

- Privacy coding document on LIS 7/19/19 was removed immediately on 10/8/19 by R. McConnell, Clinical Specialist. Documentation attached
 - Communication and Duty Binders at care bases were removed immediately on 10/18/19 by R. McConnell and placed into locked medication rooms on each floor
 - Fall prevention plan at care base was removed immediately on 10/18/19 by R. McConnell, Clinical Specialist
- All staff will be trained on keeping records confidential at the team meeting on December 18, 2019 by M. McLaughlin, PCHA. RCC or Administrator will perform twice weekly rounds through the building beginning 12/17/2019 for one month then monthly to ensure proper record keeping. Documentation of rounds and team meeting training will be kept by the administrator.

Legal Entity Representative



Signature

Michelle McLaughlin PCHA 12/17/19
Printed Name and Title Date

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The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

The above plan of correction was approved by 
(Initials)

Fully Implemented

Not Implemented

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25b - Contract Signatures

Regulations

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #2's resident-home contract, dated 1/10/17, was not signed by the resident's responsible party.

Resident #4's resident-home contract, dated 8/5/16 and resident #5's resident-home contract, dated 8/5/16 were not signed by the administrator or a designee.

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.)

M. McLaughlin had Resident contracts for #4 and #5 signed on 10/14/2019. (see attachment). Resident #2 contract not signed by responsible party, as there was no responsible party. Resident #2 signed all paperwork and is responsible for self (see attachment).

Chart audit will be conducted by Administrator or designee by 3/16/2020 ensuring all resident contracts are signed.

Chart audits will be conducted by administrator or designee to ensure all new residents within that quarters contracts are signed.

Documentation of chart audits will be kept by Administrator.

Chart audits will be conducted and all resident contracts reviewed by 1/30/2020. Beginning on 1/30/2020, the administrator or designee will review all contracts for new admissions quarterly for 1 year to ensure all resident contracts are signed.

Documentation will be submitted to the Department.

1/6/2020

All staff responsible for admissions and completing resident contracts will be educated on ensuring that all resident contracts are signed in accordance with §2600.25(b) by 1/30/2020.

1/6/2020

Legal Entity Representative

Michelle McLaughlin
Signature

Michelle McLaughlin PCNA
Printed Name and Title

12/17/19
Date

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The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

Fully Implemented

The above plan of correction was approved by *JF*
(Initials)

Not Implemented

DEC 17 2019

60a - Staff/Support Plan

Regulations

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 9/30/19, the home served 46 total residents, 9 of which had mobility needs, 2 residents required continuous oral assistance to evacuate and 1 resident required assistance of 2 staff to transfer in/out of bed or chair. The home is 3 floors with multiple areas of refuge in the East wing of every floor and the balance of the building. The home's safe evacuation time as determined by a fire safety expert on 5/1/19 is 13 minutes. The home has not conducted a fire drill with a minimum of 2 or 3 staff in the past year. However, on 9/30/19, only 2 staff were present in the home from 6:00 a.m. to 7:00 a.m. and only 3 staff were present in the home from 3:00 a.m. to 6:00 a.m. The home did not provide enough staff to assist in the safe evacuation of all residents within the established safe evacuation time to the fire safe areas in the home.

Plan of Correction (POC)

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

On 10/08/2019 R. McConnell (clinical specialist) did produce documentation that three staff members were present in the building. R. McConnell gave this information to M. Marini for review.

On 9/30/2019 Between 6 a. m. and 7 a.m. there were 3 staff members on shift. D. Swartzfager, Tami Nogel, and Pamela Knight. (see attachment)

On 11/30/2019 at 12:45 a. m. a fire drill was performed by M. Davis (maintenance) with 3 staff members on duty. Evacuation time was 8 minutes 45 seconds. (see attachment).

Administrator will continue to work with maintenance supervisor to ensure that three staff members remain able to safely evacuate all residents to fire safe areas and are able to supervise them in those fire safe areas during fire drills.

Documentation of fire drills will continue to be kept.

Beginning on 1/30/2020, the administrator or designated staff person will conduct monthly audits of the fire drill records for 1 year to ensure that the home has conducted a fire drill with the minimum number of staff needed reflecting any changes in resident mobility or care needs. 1/6/2020

Legal Entity Representative

Michelle McLaughlin
Signature

Michelle McLaughlin PCNA 12/17/19
Printed Name and Title Date

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The above plan of correction is approved as of 1/6/2020 Plan of correction implementation status as of _____
(Date) (Date)

Fully Implemented

The above plan of correction was approved by *MM*
(Initials)

Not Implemented

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82c - Locking Poisonous Materials

VACANT BELLEVILLE, MO
MUNICIPAL GOVERNMENT

Regulations

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Multiple materials with manufacturers labels indicating "If swallowed, get medical help or contact a poison control center," were unlocked, unattended and accessible to residents to include the following:

*At 10:18 a.m., under the sink in the resident's 2nd floor laundry room: 2- 10oz aerosol cans of Sani Guard Surface spray and a 32oz spray bottle of Clorox Urine Remover.

*At 11:53 a.m., under the sink in the resident's 3rd floor laundry room: a 22oz spray bottle of Spray n' Wash, 32oz spray bottle of Clorox Urine Remover, and an 88oz bottle of All Free and Clear detergent.

Not all residents of the home, including residents #2, #3, and #6, have been assessed capable of recognizing and using poisons safely.

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.)

-All chemicals were removed from all laundry rooms immediately on 10/8/19 by K. Kemmerer, Maintenance.

Signs were posted by K. Kemmerer, maintenance immediately on 10/8/19. Documentation attached

-Maintenance and or designee will conduct weekly x4 rounds, ensuring proper storage of chemicals, beginning 12/16/19, then monthly.

Documentation of rounds will be kept by the maintenance department (see attachment).

All staff persons will be educated concerning the safe storage of poisonous materials and the risks to residents by 1/30/2020.

1/6/2020

Legal Entity Representative



Signature

Michelle McLaughlin, PCAA 12/17/19

Printed Name and Title


Date

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(Date)

Plan of correction implementation status as of _____
(Date)

Fully Implemented

The above plan of correction was approved by 
(Initials)

Not Implemented

DEC 17 2019

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 11:56 a.m., both lids were open on the outside dumpster, which was filled with cardboard.

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.)

- Dumpster lid was secured with tie down immediately, 10/8/19 by K. Kømmører maintenance. Documentation attached.
- Maintenance or designee will conduct daily rounds, beginning immediately 12/17/2019 x2 months then weekly. (see attachment).

All staff persons will be educated on §2600.85(e) by 1/30/2020 and documentation will be submitted to the Department.

[Signature] 1/6/2020

Legal Entity Representative

[Signature]
Signature

Michelle McLaughlin PCH 12/17/19
Printed Name and Title Date

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The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

Fully Implemented

The above plan of correction was approved by *[Initials]*
(Initials)

Not Implemented

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #5 did not have access to a source of light that could be turned on/off at bedside.

Plan of Correction (POC)

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

-Resident #5 lamp was immediately placed at bedside by C. Lauer Resident Care Coordinator on 10/08/2019. Documentation attached

-Direct Care staff will be trained on proper lighting in a resident room on December 12/18/2019 by M. McLaughlin, PCHA. Documentation will be kept.

The administrator or designated staff person will check all resident bedrooms by 1/30/2020 to ensure that all residents have a source of light that can be turned on/off at bedside. Beginning 1/30/2020, the administrator or designated staff person will check at least 10 resident bedrooms monthly for 6 months and documentation will be kept.

[Signature] 1/6/2020

Legal Entity Representative

[Signature]
Signature

Michelle McLaughlin PCHA
Printed Name and Title Date 12/17/19

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(Date)

Plan of correction implementation status as of _____
(Date)

The above plan of correction was approved by *[Signature]*
(Initials)

Fully Implemented

Not Implemented

PROCESSED

DEC 17 2019

FOOD SERVICE INSPECTION REPORT

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

Between approximately 11:10 a.m. and 11:30 a.m., there were multiple unlabeled and undated food items in the food preparation and storage areas of the home to include the following:

- * The walk-in cooler in the kitchen: a container filled with tomato paste and a container filled with tartar sauce.
- * The dry storage area in the kitchen: a 1/3 full Ziploc bag of bread crumbs, a full stainless container of brown sugar, and a stainless container only labeled "chocolate."
- * The Bistro area freezer next to the dish washer: a plastic bag with one piece of breaded fish dated 6/29, a plastic bag of hotdogs and a sandwich bag of cut pieces of ham.

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.)

-All uncovered/unlabeled food in the walk in cooler, Bistro freezer area and dry storage area were immediately covered, sealed, labeled and dated on 10/08/2019 by G. Confer Dietary Supervisor. Documentation attached

-Dietary and Bistro supervisors, or designee will check daily to ensure all foods are covered, sealed, labeled and dated properly. Documentation will be kept. (see attached)

All staff responsible for food service and/or storage will be educated on ensuring that all food items are labeled and dated properly by 1/30/2020. Documentation will be submitted to the Department.

[Signature] 1/6/2020

Legal Entity Representative

Michelle McLaughlin
Signature

Michelle McLaughlin PCNA 12/17/19
Printed Name and Title Date

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The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

Fully Implemented

The above plan of correction was approved by *[Signature]*
(Initials)

Not Implemented

103g - Storing Food

Regulations

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

Between approximately 11:10 a.m. and 11:30 a.m., there were multiple open and unsealed food items in the food preparation and storage areas of the home to include the following:

*The walk-in cooler: a raw chicken leg, wing and breast partially covered with ice, a 1/2 full open clear container of mozzarella cheese, a 1/2 sheet of Texas sheet cake covered with plastic wrap that was ripped, 5 pounds of flank steak loosely wrapped in plastic that bled and pooled on top of a 24.95-pound box of pork loins, 1/2 of a turkey breast loosely wrapped that leaked through the bottom of the box, a 5-liter open container of beef stock, a 6-quart open container of beef stock and a 1-quart open container with pieces of zucchini and squash.

*The walk-in freezer: a sheet pan of uncovered, raw meet stuffed peppers.

*The stainless-steel side by side cooler in the kitchen: a foil pan of uncovered bacon.

*The dry food storage area: an unsealed, open 25-pound box of rice.

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.)

-All uncovered/unlabeled food in the walk in cooler, Bistro freezer area and dry storage area were immediately on 10/8/19 covered, sealed, labeled and dated by G. Confer Dietary Supervisor. Documentation attached

-Dietary and Bistro supervisors, or designee will check daily to ensure all foods are covered, sealed, labeled and dated properly (see attached check list).

Documentation will be kept (see attached).

All staff responsible for food service and/or storage will be educated on ensuring that all food items are stored in closed or sealed containers by 1/30/2020. Documentation will be submitted to the Department.

[Signature] 1/6/2020

Legal Entity Representative

[Signature]
Signature

Michelle McLaughlin PCHA 12/17/19
Printed Name and Title Date

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The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

The above plan of correction was approved by *[Signature]*
(Initials)

Fully Implemented

Not Implemented

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105g - Lint Removal and Duct Cleaning

Regulations

2600.

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

Description of Violation

At approximately 10:16 a.m., there was a layer of lint on the lint screens of the right and left side dryers in the South wing resident laundry room on the second-floor. There were no clothes in the dryer at the time.

Plan of Correction (POC)

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

- Lint was removed from the dryer and signs placed on each dryer on each floor by K. Kemmerer maintenance immediately on 10/8/19. Documentation attached
- Staff will be re-educated on removing of lint of the dryers by M. McLaughlin on 12/18/2019 at the next staff meeting.
- Staff will check lint screens each shift and document on a check sheet, attached to each dryer. Night shift supervisor will check lint screen check sheet nightly beginning December 23, 2019
- RCC or designee will collect the documentation monthly for review and filing.
- Documentation will be kept

Legal Entity Representative

Michelle McLaughlin
Signature

Michelle McLaughlin PCHM 12/17/19
Printed Name and Title Date

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The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

The above plan of correction was approved by [Signature]
(Initials)

Fully Implemented

Not Implemented

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DEC 17 2019

123b - Emergency Procedures Posted

Regulations

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures were not posted in a conspicuous and public place in the home.

Plan of Correction (POC)

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

-Emergency procedures are posted at each care base, on the side of the locked medical records carts on each floor. These emergency procedure books, remain there.

One emergency procedure book was immediately placed near the bulletin board on the second floor, outside the administrator's office by R. McConnell Clinical Specialist on 10/08/2019.

Administrator or designee will monitor monthly to ensure the binders remain in a conspicuous/public place.

All staff will be educated on §2600.123(b) and the location of the emergency procedures in the home by 1/30/2020. *[Signature]* 1/6/2020

Legal Entity Representative

[Signature]
Signature

Michelle McLaughlin ^{DCHA}
Printed Name and Title Date 12/17/19

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The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

Fully Implemented

The above plan of correction was approved by *[Signature]*
(Initials)

Not Implemented

10/17/2019

185a - Implement Storage Procedures

Regulations

2600.

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

Description of Violation

Resident #7's glucometer was not calibrated to the current date and time.

Plan of Correction (POC)

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

- Resident #7 glucometer was calibrated immediately 10/8/19 by R. McConnell Clinical Specialist. Documentation attached
- Overnight supervisor/med tech have been and will continue to check glucometers against the MAR for right time/reading. This will be documented. Documentation attached.
- Overnight supervisor/med tech will check glucometers to ensure calibrated with right date and time, notifying RCC with discrepancies. Documentation will be kept effective December 17, 2019.

All staff persons responsible for medication administration will be educated on the requirement that all glucometers are calibrated to the current date and time by 1/30/2020.

[Signature] 1/6/2020

Legal Entity Representative

[Signature]
Signature

Michelle McLaughlin PCNA
Printed Name and Title
12/17/19
Date

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The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

Fully Implemented

The above plan of correction was approved by *[Initials]*
(Initials)

Not Implemented

DEC 17 2019

191 - Resident Right to Refuse

Regulations

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #5, admitted 8/5/16, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication 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 a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- Resident #5 was notified of his right to refuse medication upon admission. Documentation attached.
 - Resident #5 responsible party signed the resident rights upon admission. Documentation attached
 - Chart audit will be conducted by Administrator or designee within 90 days of acceptance to POC, ensuring all resident rights are signed. Chart audits will be completed by 1/30/2020. *1/6/2020*
 - Chart audits will be conducted quarterly by Administrator or designee to ensure all new residents within that quarter, resident rights are signed properly.
- Documentation of chart audits will be kept by Administrator

Legal Entity Representative

Michelle McLaughlin
Signature

Michelle McLaughlin
Printed Name and Title

PCA
Date *12/17/19*

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The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

Fully Implemented

The above plan of correction was approved by *MM*
(Initials)

Not Implemented

225c - Additional Assessment

Regulations

2600.

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

- 1. Annually.

Description of Violation

Resident #2 is currently receiving hospice services; however, the resident's assessment, dated 2/28/19, did not assess the resident's need for hospice services.

Resident #4's current assessment was completed on 1/14/19. However, the resident's previous annual assessment could not be located.

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.)

- Resident #2 support plan has been updated by R. McConnell on 10/14/2019. Documentation attached.
- Resident #4 previous RASP was located by M. McLaughlin On 10/14/2019 and is attached
- Resident Care Coordinator will audit RASP monthly, beginning December 2019, for accuracy of support services. Documentation will be kept. (see attached)

All staff responsible for completing resident assessments will be educated on the importance of ensuring that assessments are completed timely and accurately. This training will be completed by 1/30/2020 and documentation will be submitted to the Department.

[Signature] 1/6/2020

Legal Entity Representative

Michelle McLaughlin
Signature

Michelle McLaughlin ^{PCA}
Printed Name and Title 12/17/19
Date

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

The above plan of correction is approved as of 1/6/2020
(Date)

Plan of correction implementation status as of _____
(Date)

Fully Implemented

The above plan of correction was approved by *[Signature]*
(Initials)

Not Implemented

DEC 17 2019

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 #4's support plan, dated 1/21/19 and resident #6's support plan, dated 12/10/18, were not signed by any of the individuals who participated in the development of the support plans.

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.)

- Resident #4 RASP was reviewed with POA and signed by current administrator on 12/04/2019.
- Resident #6 RASP indicates resident's inability to sign. This was fixed by R. McConnell on 10/14/2019.
- Resident support plans will be audited by Administrator, Resident Care Coordinator or designee by 1/30/2020.
- Resident Care Coordinator will audit RASP monthly, beginning December 2019, for signatures. Check list has been implemented. Documentation attached.

Legal Entity Representative

Michelle McLaughlin
Signature

Michelle McLaughlin PCHA 12/17/19
Printed Name and Title Date

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(Date)

Plan of correction implementation status as of _____
(Date)

The above plan of correction was approved by *MM*
(Initials)

- Fully Implemented
- Not Implemented

DEC 17 2019

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 #2's support plan, dated 2/28/19, was not signed by the resident or noted by the home that the resident refused or was unable to sign.

Resident #6's support plan, dated 3/7/19, was not signed by the resident or noted by the home that the resident refused or was unable to sign.

Resident #7's support plan, dated 11/29/18, was not signed by the resident or noted by the home that the resident refused or was unable to sign.

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.)

- Resident #2 and #6 RASP indicates resident's inability to sign. This was fixed by R. McConnell on 10/14/2019.
- Resident #7 RASP dated 11/29/18 was reviewed by R. McConnell (clinical specialist) and Resident Care Coordinator on 10/14/2019 and the inability to sign was corrected. New RASP was completed on 10/31/19 which indicates the inability to sign. This was completed by resident care coordinator.
- Resident support plans will be audited by Administrator, Resident Care Coordinator or designee by 1/30/2020
- Resident Care Coordinator will audit RASP monthly, beginning December 2019, for signatures. Check list has been implemented. Documentation attached.

Legal Entity Representative

Michelle McLaughlin
Signature

Michelle McLaughlin PCNA
Printed Name and Title
12/17/19
Date

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

The above plan of correction is approved as of 1/6/20
(Date)

Plan of correction implementation status as of _____
(Date)

The above plan of correction was approved by *JJ*
(Initials)

Fully Implemented

Not Implemented