



**Sent via e-mail [jbryan@harrisonseniorliving.com](mailto:jbryan@harrisonseniorliving.com)  
March 31, 2020**

Mr. Harrison G. Sanders  
President and CEO  
Harrison Senior Living of Coatesville, LLC  
300 Strode Avenue  
Coatesville, Pennsylvania 19320

RE: Harrison Senior Living of Coatesville  
License #: 105660

Dear Mr. Sanders:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 2 and 3, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

*Sandra Wooters*

Sandra Wooters, MHS, ACG  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

# Violation Report

## Facility Information

Name: HARRISON SENIOR LIVING OF COATESVILLE

License Number: 10566

Address: 300 STRODE AVENUE,, COATESVILLE, PA 19320

County: CHESTER

Region: SOUTHEAST

## Administrator

Name: Jeannie Bryan

Phone: 6103846310

Email: JBRYAN@HARRISONSENIORLIVING.COM

## Legal Entity

Name: HARRISON SENIOR LIVING OF COATESVILLE LLC

Address: 300 STRODE AVENUE, COATESVILLE, PA, 19320

## Certificate(s) of Occupancy

Type: C-2 LP

Date: 11/03/1986

Issued By: Dept L&I

## Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 84

Waking Staff: 63

## Inspection

Type: Full

BHA Docket #:

Notice: Unannounced

Reason: Renewal,Incident

## Inspection Dates and Department Representative

12/02/2019 - On-Site: Evelyn Perez, Sandra Wooters

12/03/2019 - On-Site: Evelyn Perez, Sandra Wooters

## Resident Demographic Data as of Inspection Dates

### General Information

License Capacity: 80

Residents Served: 69

### Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

### Hospice

Current Residents: 7

### Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 66

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 15

Have Physical Disability: 0



Action	Owner	Completion Date
Staff member A was suspended immediately.	Director of Resident Services	10/27/2019
Department of Human Services was notified by the Incident Reporting Form. Department of Aging was notified using the Mandatory Abuse Report.	Director of Resident Services Executive Director	10/28/2019
Investigation was conducted on incident that occurred. Statements were obtained by staff and resident. A review was conducted on the statements received.	Director of Resident Services Executive Director	10/28/2019
Department of Aging staff member came to facility and questioned staff and resident.	M.O.	10/29/2019
Staff Member A was terminated.	Director of Resident Services Executive Director	10/29/2019
Final report submitted to the Department of Human Services and Department of Aging.	Executive Director	10/29/2019
All staff in building were re-Inservice on OPSA.  A record of Inservice conducted was sent to the Department of Human Services.	Assistant Director of Resident Services, Education Nurse  Assistant Director of Resident Services	11/05/2019 to 11/12/2019  11/12/2019
Yearly OPSA In-services are conducted as per schedule OPSA is discussed during regular staff meeting.	Director of Resident Services Executive Director Assistant Director of Resident Services, Education Nurse	Ongoing
<b>Note:</b> On 10/29/2019 the facility requested the local Department of Aging come to facility to re-Inservice staff. Request was denied and stated DOA no longer does inservices on OPSA in facilities.	Director of Resident Services Executive Director Assistant Director of Resident Services, Education Nurse	

51 - Criminal Background Check

Regulations

2600.  
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person C, is working at the home and does not have a PA State Police Criminal Background Check.

Plan of Correction (POC)

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

*SEE ATTACHED Sheet Page 2*

Legal Entity Representative

*Jean C. Bryan*  
Signature

*Jean C. Bryan, Executive Director*  
Printed Name and Title

*2/19/20*  
Date

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(Date)

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(Date)

- Implemented
- Not Implemented

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

Action	Owner	Completion Date
Staff person C from Hospice company's PA State Police Criminal Background Check was obtained and given to State inspectors on the second day of inspection.	Director of Resident Services (DORS)	12/3/2019
Meeting was held with the Liaison from this Hospice company to re-inform them of the regulations that require PA State Police Criminal Background check for all staff that enter our building in addition to the background checks they require and perform.	DORS and Executive Director (ED)	12/16/2019
All hospice companies were re-educated that their employees must have a PA State Police criminal background check before entering facility.	DORS	12/16/2019
A review of all hospice records will be conducted during the Quarterly Quality Assurance Meeting. It will be recorded in the meeting minutes that a review was performed.	DORS and ED	4/21/2020 and ongoing
<p><b>Note:</b> A Pennsylvania statewide criminal check was conducted by the hospice company and produced to surveyors for Staff person C, on the date of request/first day of inspection (12/2/2019). The document produced to surveyor was a Report Summary completed by "PeopleFacts powered by Trak-1" for the hospice staff in question. It states, "Manual Statewide PA Criminal Search – Clear 8/28/2019 1:25:52 PM."</p>		

93b - Railings

Regulations

2600.  
93.b. Each porch must have a well-secured railing.

Description of Violation

The interior porch of the gift shop (store) is elevated approximately 1 1/3 inches from the main floor, no railings attached, causing a space for a residents foot to get caught.

Plan of Correction (POC)

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SEE ATTACHED Page 3  
SEE SAFETY Audit

Legal Entity Representative

Signature Jean C. Bryan Printed Name and Title Jean C. Bryan Executive Director Date 2/19/20

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Action	Owner	Completion Date
[REDACTED]		
A handrail was installed on the interior porch outside private dining room.	Maintenance	12/11/2019
An inspection of the interior and exterior of building was conducted to ensure facility in in compliance with Regulation 2600 93.b.	Maintenance	12/16/2019
<p>An inspection of the interior and exterior of buildings handrails was added to the safety audit checklist. Quarterly inspection will be conducted and recorded.</p> <p>The Safety Audit will be review quarterly at the safety meetings to ensure compliance and address any concerns. Safety Audit will remain part of the minutes.</p>	<p>Maintenance</p> <p>Director of Safety Executive Director</p>	<p>4/15/2020</p> <p>4/15/2020 and Ongoing</p>
See attached Safety Audit		

100a - Exterior - Free of Hazards

Regulations

2600.  
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The 2nd floor exterior covered stairwell had multiple stair treads with rusted edges causing a trip hazard.

Plan of Correction (POC)

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

SEE ATTACHED SHEET Page # 4  
SEE SAFETY Audit

Legal Entity Representative

Jean C. Bryan  
Signature

Jean C. Bryan, Executive Director  
Printed Name and Title

2/19/20  
Date

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<b>Action</b>	<b>Owner</b>	<b>Completion Date</b>
The covers for the treads for the exterior stairwell that were rusted and in need of replacing was conducted.	Maintenance Department	12/05/2019
An inspection of the exterior of building was conducted to ensure the buildings grounds and yard are in good repair and free of hazards.	Maintenance Department	12/10/2019
An inspection of the treads for stairwells, along with the exterior grounds and yard of facility was added to the safety audit. Inspections will be conducted and recorded on a quarterly basis.	Maintenance Department	4/15/2020
The Safety Audit will be review at Safety Meeting quarterly to oversee audits. Also, to ensure compliance and to make sure issues are addressed. Safety Audits will remain part of the minutes.	Safety Director Executive Director	4/15/2020 and Ongoing
See Attached Safety Audit		

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

The door to the 2nd floor exterior stairwell was difficult to open and had to be pushed on multiple times to open. Department representative was not able to open door.

Plan of Correction (POC)

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

SEE ATTACHED SHEET Page 5  
SEE SAFETY Audit

Legal Entity Representative

Signature Jean C. Bryan

Printed Name and Title Jean C. Bryan Executive Director Date 2/19/20

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Action	Owner	Completion Date
The door to the 2 <sup>nd</sup> floor exterior stairwell was repaired to ensure door is easier to open for any person. Doorknob was also replaced.	Maintenance	12/06/2019
An inspection of all passageways and egress doors were inspected to make sure doors could easily be open. Any issues were addressed.	Maintenance	12/11/2019
An inspection of exterior doors will be added to the safety audit. The Safety Audit will be conducted and recorded quarterly. Any problem items will be addressed.	Maintenance	4/15/2020 and Ongoing
The Safety Audit will be review at Safety Meeting quarterly to oversee audits. Also, to ensure compliance and to make sure issues are addressed. Safety Audits will remain part of the minutes.	Safety Director Executive Director	4/15/2020 and Ongoing
See attached Safety Audit		
<b>Note:</b> The exterior door in question was not locked nor obstructed.		

132g - Fire Drills Days/Times

Regulations

2600.  
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The fire drills completed on 08/29/19, 09/29/19 and 10/24/19 were all completed on a Thursday.

Plan of Correction (POC)

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SEE ATTACHED Sheet Page 6

Legal Entity Representative

Jean C. Bryan  
Signature

Jean C. Bryan Executive Director <sup>2/19/20</sup>  
Printed Name and Title Date

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Action	Owner	Completion Date
<p>It should be noted that page 7 of the Licensing Inspection Summary Report dated 2/5/2020 has an error. The date listed in the report is 9/29/2019, which is a Sunday and not when the fire drill occurred. The fire drill in question occurred on 9/26/2019, a Thursday. This is important to be aware of as we are being cited for having three fire drills on a Thursday.</p>		
<p>Ongoing, Fire Drills will be conducted on different days of the week. Facility will be more aware not to conduct fire drill on the same day of the week in two or more consecutive months.</p>	<p>Assisted Director of Resident Services Safety Director</p>	<p>1/1/2020 and Ongoing</p>
<p>A review of the Yearly schedule and monthly fire drill will be added to the Quality Assurance minutes. Staff at Quarterly Quality Assurance Meetings will ensure compliance.</p>	<p>Director of Resident Services Executive Director</p>	<p>4/15/20 and ongoing</p>

181e - Capable to Self Administer

Regulations

2600.

181.e. To be considered capable to self-administer medications, a resident shall:

- 1. Be able to recognize and distinguish his medication.
- 2. Know how much medication is to be taken.
- 3. Know when medication is to be taken.

Description of Violation

Resident #2 self-administers her medications. On 2/18/19, the resident was unable to recognize and distinguish her medication and say when she takes her medication.

Plan of Correction (POC)

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

SEE ATTACHED SHEET Page 7  
SEE ATTACHED Inservice sheets for  
SELF Administration of Medications.

Legal Entity Representative

Jean C. Bryan  
Signature

Jean C. Bryan, Executive Director  
Printed Name and Title

2/19/20  
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Action	Owner	Completion Date
It should be noted on page 8 of the Licensing Summary Report that "On 2/18/19, the resident was unable to recognize and distinguish her medication and say when she takes her medication." This date is in question due to no surveyors being present in this building.		
Resident #2's Medication was immediately removed from resident's room and placed in facilities locked medication cart.	Director of Resident Services	12/3/2019
Resident #3's Ointment was immediately moved to the facilities locked medication cart.	Director of Resident Services	12/3/2019
Resident #2's medical POA, and POA was notified of the outcome of inspection and reason for removal of medication from resident's room.	Executive Director	12/3/2019
Medication administered by med tech or LPN for Resident #2	Med Tech, LPN	Evening med pass on 12/3/2019
A review of all self-medicating residents in facility was performed to ensure compliance with Regulation 2600 181.e, 183.a and 183.b. Changes were made if needed.	Director of Resident Services	12/10/2019
Before a new resident can self-medicate, the resident must have an order from their PCP along with being able to show DORS or designee they are able to comply with Regulation 2600 181.e and 183.a	Director of Resident Services Assistant Director of Resident Services	12/4/19 and Ongoing
A review of all self-medicating residents will be done once a year at the time residents DME is due.	Director of Resident Services Assistant Director of Resident Services	Ongoing
RN, LPNs and Med Tech staff inservice on self-medication and Regulation 183.b on storage of medications.	Director of Resident Services Assistant Director of Resident Services	12/13/2019 thru 12/24/2019 2/28/2020
See attached Inservice on Self -Medication		

183a - Original Containers and Injections

Regulations

2600. 183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

Resident #2 is unable to fill her medication box independently and said her daughter fills it weekly.

Plan of Correction (POC)

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

SEE ATTACHED sheet Page 7

Legal Entity Representative

Signature Jean C. Bryan

Jean C. Bryan Executive Director 2/19/20  
Printed Name and Title Date

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Action	Owner	Completion Date
It should be noted on page 8 of the Licensing Summary Report that “On 2/18/19, the resident was unable to recognize and distinguish her medication and say when she takes her medication.” This date is in question due to no surveyors being present in this building.		
Resident #2’s Medication was immediately removed from resident’s room and placed in facilities locked medication cart.	Director of Resident Services	12/3/2019
Resident #3’s Ointment was immediately moved to the facilities locked medication cart.	Director of Resident Services	12/3/2019
Resident #2’s medical POA, and POA was notified of the outcome of inspection and reason for removal of medication from resident’s room.	Executive Director	12/3/2019
Medication administered by med tech or LPN for Resident #2	Med Tech, LPN	Evening med pass on 12/3/2019
A review of all self-medicating residents in facility was performed to ensure compliance with Regulation 2600 181.e, 183.a and 183.b. Changes were made if needed.	Director of Resident Services	12/10/2019
Before a new resident can self-medicate, the resident must have an order from their PCP along with being able to show DORS or designee they are able to comply with Regulation 2600 181.e and 183.a	Director of Resident Services Assistant Director of Resident Services	12/4/19 and Ongoing
A review of all self-medicating residents will be done once a year at the time residents DME is due.	Director of Resident Services Assistant Director of Resident Services	Ongoing
RN, LPNs and Med Tech staff Inservice on self-medication and Regulation 183.b on storage of medications.	Director of Resident Services Assistant Director of Resident Services	12/13/2019 thru 12/24/2019 2/28/2020
See attached Inservice on Self -Medication		

183b - Meds and Syringes Locked

Regulations

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

Resident #3 is unable to self-administer medications. On 12/03/2019, there were two containers of Calmoseptrie Ointment found on his dresser unlocked.

Resident #3 resides in a room with his wife who had medications in their room unlocked and accessible to him which included Atorvastatin, Amlodipine, Aspirin, Donepezil, Furosemide, Latanoprost, Lisinopril, Namenda, Omega 3 and Omeprazole.

Plan of Correction (POC)

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

*See attached Sheet Page 7*

Legal Entity Representative

*Jean C. Bryan*  
Signature

*Jean C. Bryan, Executive Director*  
Printed Name and Title

*2/19/20*

Date

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Action	Owner	Completion Date
It should be noted on page 8 of the Licensing Summary Report that “On 2/18/19, the resident was unable to recognize and distinguish her medication and say when she takes her medication.” This date is in question due to no surveyors being present in this building.		
Resident #2’s Medication was immediately removed from resident’s room and placed in facilities locked medication cart.	Director of Resident Services	12/3/2019
Resident #3’s Ointment was immediately moved to the facilities locked medication cart.	Director of Resident Services	12/3/2019
Resident #2’s medical POA, and POA was notified of the outcome of inspection and reason for removal of medication from resident’s room.	Executive Director	12/3/2019
Medication administered by med tech or LPN for Resident #2	Med Tech, LPN	Evening med pass on 12/3/2019
A review of all self-medicating residents in facility was performed to ensure compliance with Regulation 2600 181.e, 183.a and 183.b. Changes were made if needed.	Director of Resident Services	12/10/2019
Before a new resident can self-medicate, the resident must have an order from their PCP along with being able to show DORS or designee they are able to comply with Regulation 2600 181.e and 183.a	Director of Resident Services Assistant Director of Resident Services	12/4/19 and Ongoing
A review of all self-medicating residents will be done once a year at the time residents DME is due.	Director of Resident Services Assistant Director of Resident Services	Ongoing
RN, LPNs and Med Tech staff Inservice on self-medication and Regulation 183.b on storage of medications.	Director of Resident Services Assistant Director of Resident Services	12/13/2019 thru 12/24/2019 2/28/2020
See attached Inservice on Self -Medication		

190c - Record of Training

Regulations

2600.  
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The initial summary and certification for staff person D does not include any indication of staff passing or failing the medications administration training and the training score was not tallied.

The annual practicum for Staff E, does not include any med pass for the 2019, annual practicum and only one MAR review document dated 12/12/2018.

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 ATTACHED SHEET Page 8

Legal Entity Representative

*Jean C. Bryan*  
Signature

*Jean C. Bryan Executive Director* *2/19/20*  
Printed Name and Title Date

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Action	Owner	Completion Date
<p><b>Note:</b> Staff person D successfully completed and passed the Med Tech training class. All documentation (Certificate of Passing Medication Administration Training, Copy of Test completed, and Test scores) were shown to surveyor during inspection.</p>		
<p>DORS failed to check the pass or fail line at the bottom of the sheet and tally the score of 100. DORS checked the pass line and put a tally score of 100 at bottom of tally score sheet during inspection.</p>	Director of Resident Services (DORS)	12/3/2019
<p>A review of all Med Tech Training sheets will be added to the agenda at the Quarterly QA meeting. A review will occur at the quarterly QA meetings to ensure all sheets are properly completed.</p>	Executive Director	4/15/2020 and ongoing
<p><b>Note:</b> The Annual practicums for Staff E were completed and logged on the Annual Practicum sheets but were not transcribed to the Med Administration Record Review Sheets.            Dates of MAR review were completed in 2018 on 3/14/18, 7/25/18 and 12/12/18. Dates of MAR review were completed in 2019 on 2/20/19, 5/14/19 and 9/2/19.</p> <p>The dates for Staff E Annual Practicum Sheets were transcribed to the Med Administration Record Review Sheets.</p>	Director of Resident Services (DORS)	
	Director of Resident Services (DORS)	12/4/2019
<p>The review of the Annual Practicum Sheet and the Med Administration will be put on the agenda at the Quarterly QA meetings. A review will occur at each quarterly QA meetings to ensure all sheets are properly filled out.</p>	Executive Director	April 15/2019 and ongoing

225a - Assessment 15 Days

Regulations

2600.  
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

The initial assessments for residents 4, 5, 6 and, 7 were not completed within 15 days of admission. Initial Assessment Dates are prior to Date of Admission.

Plan of Correction (POC)

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

*See ATTACHED Sheet Page 9*

Legal Entity Representative

*Jean C. Bryan*  
Signature

*Jean C. Bryan Executive Director*  
Printed Name and Title

*2/19/20*  
Date

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<p><b>Note:</b> The Initial Assessment for residents 4, 5, 6, and 7 were completed within the 15 days of admission. Staff person placed the date the physicians completed their assessment in the initial assessment date instead of date of completed assessment. This was made aware to inspector at time of inspection and noted. Therefore, the date was prior to the date of admission.</p>		
<p>The ADORS was re-in serviced on the proper way to fill out Initial Assessments for residents.</p>	Director of Resident Services	12/4/2019
<p>A review of all initial assessments in the facility was completed to ensure compliance.</p>	Director of Resident Services (DORS)	1/3/2020
<p>All initial assessment for each resident will be completed within 15 days of admission. Point Click Care and tickler system will help assist with this process.</p>	Assistant Director of Resident Services (ADORS)	1/3/2020
<p>After the initial assessment of each resident is completed it will be review before being part of the resident's record.</p>	Director of Resident Services (DORS)	1/3/2020