pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail srmcsmith@aol.com
April 24, 2020

Ms. Shelley R. Smith
Administrator
Shelley R. Smith
5224-26 North Broad Street
Philadelphia, Pennsylvania 19141

RE: Broad Street Residence
License #: 176360

Dear Ms. Smith:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 5, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Shawn Parker

Shawn Parker
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *BROAD STREET RESIDENCE* License Number: *17636*
Address: *5224-26 NORTH BROAD STREET,, PHILADELPHIA, PA 19141*
County: *PHILADELPHIA* Region: *SOUTHEAST*

Administrator

Name: *Shelly Smith* Phone: *2153242370* Email: *SRMCSMITH@AOL.COM*

Legal Entity

Name: *SHELLEY R. SMITH*
Address: *5224-26 NORTH BROAD STREET, PHILADELPHIA, PA, 19141*

Certificate(s) of Occupancy

Type: *I-1* Date: *08/02/1991* Issued By: *City Of Philadelphia L&I*

Staffing Hours

Resident Support Staff: *50* Total Daily Staff: *74* Waking Staff: *56*

Inspection

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

Inspection Dates and Department Representative

03/05/2020 - On-Site: Christina Eberhart, Shawn Parker

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* Residents Served: *24*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *18*
Are 60 Years of Age or Older: *8*
Diagnosed with Mental Illness: *24*
Diagnosed with Intellectual Disability: *6*
Have Mobility Need: *0*
Have Physical Disability: *0*

88a - Surfaces

Regulations

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

In the 2nd floor bathroom on the 224 side of the home, observed the ceiling in the shower peeling and in disrepair.

In the 2nd floor hallway on the 224 side, observed wallpaper peeling and in disrepair.

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 1

PLEASE SEE ATTACHED.....

Legal Entity Representative

Signature

Shelley R. Smith, Admin. 4/6/2020
Printed Name and Title Date

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

The above plan of correction is approved as of 04-23-2020 (Date)

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

Plan of correction implementation status as of 04-23-2020 (Date)

☑ Implemented
☐ Not Implemented

Inspection Date: March 5, 2020

Regulation: 2600.88.a – Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Violation Description: In the 2nd floor bathroom, observed the ceiling in the shower peeling and in disrepair.

In the 2nd floor hallway, observed wallpaper peeling and in disrepair.

CORRECTIVE ACTION: The shower ceiling has been spackled and painted. The hallway wallpaper has been removed and the wall has been spackled and painted. Pictures of the completed repairs are enclosed. In the future, the administrator will ensure that all shower ceilings and hallways are maintained in good repair. Housekeeping staff will inspect hallways and bathrooms when performing daily housekeeping duties. These inspections will be added to the daily preventative maintenance schedule. All repairs needed will be reported to the administrator weekly for immediate corrective action.

Shirley R. Smith
4/6/20

89b - Hot Water Temperature

Regulations

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 3/5/20, the hot water temperature in the 3rd floor hallway bathroom on the 224 side measured 123.4 degrees Fahrenheit.

On 3/5/20, the hot water temperature in the 3rd floor hallway bathroom on the 226 side measured 124.3 degrees Fahrenheit.

On 3/5/20, the hot water temperature in the 2nd floor hallway bathroom on the 224 side measured 125 degrees Fahrenheit.

On 3/5/20, the hot water temperature in the 2nd floor hallway bathroom on the 226 side measured 124.1 degrees Fahrenheit.

Repeat Violation: 5/8/19 et al

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 2

PLEASE SEE ATTACHED.....

Water log form to be kept for Department review..... SP 04-23-2020

Legal Entity Representative

Shelley R. Smith — Signature

Shelley R. Smith Admin. — Printed Name and Title

4/6/20 — Date

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☑ Implemented
☐ Not Implemented

Inspection Date: March 5, 2020

Regulation 2600.89b – Hot water temperature in areas accessible to the resident may not exceed 120 degrees F.

Violation Description: Hot water temperature in the 3rd floor bathroom on the 5224 side measured 123.4 degrees F. Hot water temperature in the 3rd floor bathroom on the 5226 side measured 124.3.
Hot water in the 2nd floor bathroom on the 5224 side measured 125 degrees F. Hot water in the 2nd floor bathroom on the 5226 side measured 124.1 degrees F.

CORRECTIVE ACTION: Housekeeping staff will check the water temperature daily using the new thermometer recently purchased. Water temperatures will be recorded on the attached form. All staff have been trained and instructed to allow the water to run for 40 seconds before taking the temperature, to obtain a more accurate reading. If temperatures exceed 120 degrees F., staff will immediately notify the administrator so an adjustment can be made.

Sherry R. Smith
4/16/20

95 - Furniture and Equipment

Regulations

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The picnic table on the far side of the designated smoking area is broken and in disrepair. The legs are wobbly and the table is shaky.

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 3

PLEASE SEE ATATCHED.....

Legal Entity Representative

Shelley R. Smith — Shelley R. Smith Administrator — 4/6/20

Signature | Printed Name and Title | Date

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☐ Not Implemented

Inspection Date: March 5, 2020

Regulation: 2600.95 Furniture and equipment must be in good repair and free from hazards.

Violation Description: The picnic table on the far side of the designated smoking area is broken and in disrepair. The legs are wobbly and the table is shaky.

CORRECTIVE ACTION: The picnic table has been replaced. A picture of the new table is enclosed. Direct Care staff will perform weekly inspections of the furniture in the designated smoking area. Any furniture found needing repair will be documented. These inspections will be added to the daily preventative maintenance schedule. Repairs needed will be reported to the administrator weekly for immediate corrective action.

Corrective action was initiated on March 5, 2020, (shaky table removed) and completed March 11, 2020 (new table put in smoking area).

101j6 - Mirror

Regulations

2600.
101.j. Each resident shall have the following in the bedroom:
6. A mirror.

Description of Violation

There is no mirror in the bedroom #5 on the second floor.

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 4

PLEASE SEE ATTACHED

Legal Entity Representative

Signature

Shelley R. Smith Administrator 4/6/20
Printed Name and Title Date

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Inspection Date: March 5, 2020

Regulation: 2600.101.j Each resident shall have the following in the bedroom: a mirror

Violation Description: There is no mirror in bedroom #5 on the second floor.

CORRECTIVE ACTION: A mirror has been placed in bedroom #5. All staff have been trained on 2600.101, focusing on items that are required in bedrooms. Housekeeping staff will inspect bedrooms when performing daily duties and document if any items are missing. These inspection reports will be added to the daily preventative maintenance schedule. Said reports will be reviewed weekly by the administrator for immediate corrective action.

Corrective action was completed March 9, 2020.

Shirley R. Smith
4/6/20

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

On 03-05-2020 beef was observed in the basement freezer dated "3-20". Prunes in the first floor refrigerator dated "1-2020". Tea bags and dried mashed potatoes in dry storage room dated "3-20". Grits in the dry storage room dated "2020". Spaghetti in the dry storage room dated 5-22. All of these items were just labeled with the month and year.

Observed ½ cheese sandwich, salami and cheese, a large container of Kool-Aid, a container of gravy, and 2 pitchers of beverages in first floor refrigerator not labeled or dated.

In the dry storage room, on top of the refrigerator, observed a large plastic container with several bags of cereal in plastic bags with no label and no date. Observed Amor Spanish Carolina Rice in a plastic container on the storage shelf in the dry storage room. The rice was not dated.

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 5

Legal Entity Representative

Signature

Shelley N. Smith Admin. — Printed Name and Title

4/3/20 — Date

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☑ Implemented
☐ Not Implemented

Inspection Date: March 5, 2020

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

On 03-05-2020 beef was observed in the basement freezer dated "3-20". Prunes in the first floor refrigerator dated "1-2020". Tea bags and dried mashed potatoes in dry storage room dated "3-20". Grits in the dry storage room dated "2020". Spaghetti in the dry storage room dated 5-22. All of these items were just labeled with the month and year.

Observed ½ cheese sandwich, salami and cheese, a large container of Kool-Aid, a container of gravy, and 2 pitchers of beverages in first floor refrigerator not labeled or dated.

In the dry storage room, on top of the refrigerator, observed a large plastic container with several bags of cereal in plastic bags with no label and no date. Observed Amor Spanish Carolina Rice in a plastic container on the storage shelf in the dry storage room. The rice was not dated.

CORRECTIVE ACTION: All of the above mentioned items have been correctly labeled and properly dated with the day, month and year. The administrator will evaluate all food purchases for the following risks: outdated food, dented cans and potentially hazardous food brought into the home. The primary benefit is to protect the health and welfare of the residents and reduce waste due to early food expiration and contamination. The following procedures will be followed when food deliveries are received:

1. Staff responsible for receiving food purchases must fully check every delivered order for accurate quantity, quality and usability.

2. All food purchases will be properly stored away: labeled and dated. After being checked, any cans with dents will be removed from the storage area and placed on the "dented cans holding shelf" to be returned to the supplier. All frozen foods requiring repackaging will be correctly labeled and dated with the day, month and year.

3. All food, cold and dry storage area shall have labels with the date it was packaged and its expiration date that is visible and easily read.

Corrective action was completed March 9, 2020.

Shelly R. Smith
4/3/20

103f - Refrigerator/Freezer Temps

Regulations

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 3/5/20 at 10:20 am the temperature in the bread freezer in the basement was 50 degrees Fahrenheit.

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 6

Admin or designee will ensure all refrigerators and freezers in the home are within temperature ranges expressed in regulation 2600.103f.
SP 04-23-2020

Legal Entity Representative

Signature | Shelley F. Smith Admin (Printed Name and Title) | 4/3/20 (Date)

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Plan of correction implementation status as of 04-23-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

Inspection Date: March 5, 2020

Regulation 2600.103f: Food requiring refrigeration shall be stored at or below 40 degrees F. Frozen food shall be kept at or below O degrees F. Thermometers are required in refrigerators and freezers.

Violation Description: On 3/5/20 at 10:20 am the temperature in the bread freezer was 50 degrees F.

CORRECTIVE ACTION: On 3/5/20 the freezer was operating, however, the thermometer in the freezer was broken. A new thermometer was placed in the freezer. Staff will check the thermometer whenever a bread delivery is received and placed in the freezer. This will ensure the proper temperature is maintained and displayed accurately.

Corrective action was completed March 13, 2020.

4/3/20

103i - Outdated Food

Regulations

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

In the canned food area located in the basement, there was 1 can of kernel corn, 1 can of stewed tomatoes, and 1 unidentified can all dented and not in the designated dented can area.

In the refrigerator located in the dry storage area, there were several loaves of expired bread. Some dates were 12/9/19, 12/11/19, 1/2/20, 1/4/20, and 1/5/20.

On the shelf in the dry storage room, there was a bottle of French style salad dressing with a "best by" date of 10/6/18.

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 7

PLEASE SEE ATTACHED.....

Legal Entity Representative

Signature | Shelley R. Smith Administrator (Printed Name and Title) | 4/3/20 (Date)

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☑ Implemented
☐ Not Implemented

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Inspection Date: March 5, 2020

Regulation 2600.103.i: Outdated or spoiled food or dented cans may not be used.

Violation Description: There was 1 can of kernel corn, 1 can of stewed tomatoes, and 1 unidentified can all dented and not in the designated dented can area. There were several loaves of expired bread. There was a bottle of French Style dressing with a "best by" date of 10/6/18,

CORRECTIVE ACTION: All dented cans and food items with expiration dates were immediately removed from the food storage area. A monthly food audit will be performed by the manager identifying any food items with an expiration date coming within 5 days. These items will be removed from storage to be used within 2-4 days. Any dented cans found will be placed on the shelf designated for dented cans. During monthly staff meetings, the administrator will review and teach appropriate food and safety policies to reduce residents' exposure to potentially hazardous canned or box foods.

Corrective action was completed March 5, 2020.

Shelley R. Smith
4/3/20

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

On 3/5/20, there was an accumulation of lint in the lint traps of both dryers in the laundry room. There were no clothes in the dryers at the time.

Repeat Violation: 5/8/18 et al.

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 8

PLEASE SEE ATTACHED.....

Legal Entity Representative

Shelley R. Smith

Signature

Shelley R. Smith, Admin. 4/3/20

Printed Name and Title / Date

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Plan of correction implementation status as of 04-23-2020 (Date)

☑ Implemented
☐ Not Implemented

Inspection Date: March 5, 2020

Regulation 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.

Description of Violation: On 3/5/20 there was an accumulation of lint in the lint traps of both dryers in the laundry room. There were no clothes in the dryers at the time.

CORRECTIVE ACTION: The administrator has re-trained all staff on 2600.105.g reiterating the need to empty dryer lint traps after each use. The manager will check the lint traps daily after laundry has been completed to ensure they've been emptied and report same to the administrator. A reminder poster has been hung in the laundry room (enclosed).

Corrective action was completed March 6, 2020.

Shirley R. Smith
4/3/20

121a - Unobstructed Egress

Regulations

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 3/5/20, the first level storm door, which is a fire exit, was locked. The gate outside of home leading to front lawn was also locked. This gate is used as a fire exit.

Plan of Correction (POC)

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

See Page 9

Admin or designee will ensure all stairways, hallways, doorways, passageways, and egress routes are unlocked and unobstructed.

SP 04-23-2020

Legal Entity Representative

Signature | Shelley P. Smith Admin. Printed Name and Title | 4/6/20 Date

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Plan of correction implementation status as of 04-23-2020 (Date)

☑ Implemented
☐ Not Implemented

Inspection Date: March 5, 2020

Regulation 2600.121.a: Stairways, hallways, doorways, passageways and egress routes from rooms and from the buildining must be unlocked and unobstructed.

Description of Violation: On 3/5/20, the first level storm door, which is a fire exit, was locked. The gate outside of home leading to the front lawn was also locked. This gate is used as a fire exit.

CORRECTIVE ACTION: The first level storm door, which is a fire exit and the outside gate leading to the front lawn, also a fire exit are equipped with a Department approved knob which allows immediate egress in case of fire or other emergency. (picture enclosed) The doors and gate are not equipped with a "key-locking device" which is prohibited. These exits are used during fire drills and allow immediate egress and pose no danger to the residents.

Shelley R. Sawicki
4/6/20

132c - Fire Drill Records

Regulations

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 10/23/19 does not include the evacuation 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.)

See Page 10

PLEASE SEE ATTACHED.....

Legal Entity Representative

Signature

Shelley R. Smith Admin. 4/6/20

Printed Name and Title / Date

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☑ Implemented
☐ Not Implemented

Date of Inspection: March 5, 2020

Regulation: 2600.132.c:

Description of Violation: The fire drill record for the drill conducted on 10/23/19 does not include the evacuation time.

CORRECTIVE ACTION: The administrator, manager and staff will ensure that each section of the monthly fire drill log is filled out completely. In order to prevent errors and a repeat of the current violation, the administrator and staff will audit the fire drill records monthly. This audit will consist of a visual review of the form; checking to ensure that the form is not missing any required information.

These procedures will assist the home in maintaining compliance with the Regulatory Compliance Guide Chapter 2600 55 PA Code.

Shelly R Smith
4/6/20

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 2019 medical evaluation was not completed. The resident's previous medical evaluation was completed on 8/22/18.

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 11

Admin or designee will ensure all residents have Documented Medical Evaluation form completed annually.

SP 04-23-2020

Legal Entity Representative

Shelley R. Smith — Signature

Shelley R. Smith, Admin. — Printed Name and Title

4/6/20 — Date

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☑ Implemented
☐ Not Implemented

Date of Inspection: March 5, 2020

Regulation 2600.141.b.1: A resident shall have a medical evaluation annually.

Description of Violation: Resident #1's 2019 medical evaluation was not completed. The resident's previous medical evaluation was completed on 8/22/18.

CORRECTIVE ACTION: Resident #1 moved from the residence on October 1, 2019. His notice was given to the home on September 1, 2019. On August 5, 2019, a medical evaluation form was given to the case manage because the resident sees his PCP at Horizon House. The case manager was informed that the medical evaluation was due prior to September 5, 2019. Due to the fact that the resident had planned to move, the medical evaluation wasn't returned to the home.

When a resident sees a PCP in the community, the administrator will continue to provide medical evaluation forms to case managers at least 30 days in advance with instructions that the form must be completed and returned even if the resident has given notice to relocate. This will be documented in the resident file with a signature obtained from the case manager. These procedures will assist the home in maintaining compliance.

Sherry R. Smith
4/6/20

183c - Refrigerated Meds Locked

Regulations

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On 3/5/20, Lantus Solostar 100 units prescribed for resident #2, was unlocked and accessible in the refrigerator on the first floor.

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 12

PLEASE SEE ATTACHED.....

Legal Entity Representative

Shelley R. Smith — Shelley R. Smith Administrator — 4/6/20

Signature | Printed Name and Title | Date

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☑ Implemented
☐ Not Implemented

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

Date of Inspection: March 5, 2020

Regulation: 2600.183.c: Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation: Lantus Solostar 100 units prescribed for resident #2, was unlocked and accessible in the refrigerator.

CORRECTIVE ACTION: An additional lock box was purchased so that all insulin can be kept locked in the refrigerator. One box will contain Humalog and one box will contain lantus. The manager will perform a weekly audit of insulin to ensure refrigerated meds are properly locked in order to prevent this violation from reoccurring.

Corrective action was completed March 10, 2020.

Shelley R. Smith
4/6/20

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

An assessment was not completed for resident #1, who was admitted to the home on 8/31/18.

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 13

Admin or designee will ensure that within 15 days of admission, an initial assessment is completed for all residents on the Departments assessment form. Form to be maintained for Department review.

SP 04-23-2020

Legal Entity Representative

Signature

Shelley R. Smith, Admin, 4/6/20
Printed Name and Title Date

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☑ Implemented
☐ Not Implemented

225c - Additional Assessment

Regulations

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

Description of Violation

Resident #1's most annual assessment for 2019 was not completed.

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 13

PLEASE SEE ATTACHED.....

Legal Entity Representative

Signature | Shelley R. Smith Admin (Printed Name and Title) | 4/6/20 (Date)

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Date of Inspection: March 5, 2020

Regulation 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: An assessment was not completed for resident #1, who was admitted to the home on 8/31/18.

Regulation 2600.225.c : The resident shall have additional assessments as follows: 1. annually

Description of Violation: Resident #1's most annual assessment for 2019 was not completed.

CORRECTIVE ACTION: The initial assessment for new residents will be completed within 15 days of admission as required. An additional assessment will be completed annually as required. The manager will review all new resident files after completion by the administrator and before they are filed with other records. This audit/review will check for all Department required forms. In addition, the manager will perform a quarterly audit/review of resident records to ensure required forms have been completed on time. These procedures will ensure continued compliance.

Sherry R. Smith

4/6/20

227a - Support Plan 30 Days

Regulations

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted on 8/31/18; however, the resident's initial support plan was not completed.

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.)

Admin or designee will ensure that all residents have a written support plan developed and implemented within 30 days of admission to the home.

SP 04-23-2020

See PAGE 14

PLEASE SEE ATTACHED.....

Legal Entity Representative

Signature | Printed Name and Title | Date

Sheila R. Smith Admin. 4/6/20

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

The above plan of correction is approved as of 04-23-2020 (Date)

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

Plan of correction implementation status as of 04-23-2020 (Date)

☑ Implemented
☐ Not Implemented

227c - Support Plan Revision

Regulations

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #1's annual support plan for 2019 was not completed.

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 14

PLEASE SEE ATTACHED.....

Legal Entity Representative

Signature | Printed Name and Title | Date

Shelly R. Smith Admin 4/6/20

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The above plan of correction is approved as of 04-23-2020 (Date)

Plan of correction implementation status as of 04-23-2020 (Date)

☑ Implemented
☐ Not Implemented

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

Date of Inspection: March 5, 2020

Regulation 2600.227.a: A resident requiring personal care shall have a written support plan developed and implemented with 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation: Resident #1 was admitted on 8/31/18, however, the initial support plan was not completed.

Regulation 2600.227.c: The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation: Resident #1's annual support plan for 2019 was not completed.

CORRECTIVE ACTION: The initial support for new residents will be completed within 30 days of admission as required. An additional support plan will be completed annually as required. The manager will review all new resident files after completion by the administrator and before they are filed with other records. This audit/review will check for all Department required forms. In addition, the manager will perform a quarterly audit/review of resident records to ensure required forms have been completed on time. These procedures will ensure continued compliance.

Shirley R. Smith

4/6/20