Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

September 8, 2023

[redacted], ADMINISTRATOR
JAMESON CARE CENTER, INC.
3345 WILMINGTON ROAD
NEW CASTLE, PA, 16105

RE: JAMESON PLACE
3345 WILMINGTON ROAD
NEW CASTLE, PA, 16105
LICENSE/COC#: 40128

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/23/2023, 05/24/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *JAMESON PLACE* **Licen e #**: *40128* **Licen e Expiration**: *08/23/2023*

Address: *3345 WILMINGTON ROAD, NEW CASTLE, PA 16105*

County: *LAWRENCE* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *JAMESON CARE CENTER, INC.*

Address: *3345 WILMINGTON ROAD, NEW CASTLE, PA, 16105*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *03/03/1998* **I ued By**: *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/24/2023*

Inspection Dates and Department Representative

05/23/2023 On Site [redacted]

05/24/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *71* **Residents Served**: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

05/23/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/18/2023*

06/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/18/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/10/2023*

Inspections / Reviews *(continued)*

07/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/18/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/20/2023*

09/08/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/18/2023*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

82a - Poisonous Materials

1. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 5/23/23 at 12:30 p.m., a 3/4 full small spray bottle containing a blue liquid with "floor cleaning" written on it was found in the 1st floor laundry room chemical closet. However, the original product labeling was not present on the bottle.

On 5/23/23 at 12:30 p.m. a 3/4 full 500ml spray bottle containing a clear with "bathroom cleaner" written on it was found in the 3rd floor chemical closet. However, the original product labeling was not present on the bottle.

Plan of Correction ***Accept [redacted] - 07/13/2023)***

On 5/23/23 all unauthorized cleaning agents were removed from the building and disposed of. All staff, including housekeeping has been educated on the proper storage, proper labeling and use of all cleaning agents. Administrator will observe and monitor to ensure compliance.

All unauthorized cleaning agents were removed by EVS staff on 5-23-23.
All staff were educated on the proper storage, proper labeling, and use of all cleaning products by the Administrator on 5-26-23.
Observation began on 6-5-23 and will be conducted monthly.

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented [redacted] - 09/08/2023)

86b - Bathroom

2. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 5/23/23, none of the bathrooms on any floors of the home had an operable window or ventilation fan. The ventilation fans were all inoperable.

Plan of Correction ***Accept ([redacted] - 07/13/2023)***

Jameson Place building exhaust fan was repaired by our outside HVAC contractor on 6-1-2023. Unit was serviced and checked for performance to ensure 24hr exhaust is maintained. A belt was replaced and tightened. Unit was nspected and is running properly at this time. Jameson Place staff and EVS staff will check on weekly rounds to ensure operation is maintained.

have attached the service order for this repair.

Rounding began on 6-1-23.

86b - Bathroom *(continued)*

Licensee's Proposed Overall Completion Date: *07/06/2023*

Implemented (SQ - 09/08/2023)

91 Telephone Numbers

3. Requirements

2600.
91. Emergency Telephone Numbers Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 5/23/23 at 12:20 p.m., there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone with an outside line in the basement of home.

Plan of Correction ***Accept (- 07/13/2023)***

On 5/23/23 emergency numbers were posted by the telephone in question. The Director of Environmental Services will monitor to ensure all phones in the basement have the numbers posted.
I have attached a picture of the phone and the appropriate signage.

The numbers were posted by the Director of Environmental Services. Monitoring began that day and will continue to be checked weekly by the EVS staff.

Licensee's Proposed Overall Completion Date: *07/06/2023*

Implemented (- 09/08/2023)

92 Windows

4. Requirements

2600.
92. Windows and Screens Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 5/23/23, the windows that open to the exterior of the home in the 2nd and 3rd floor east end fire stairwells and resident bedroom #308 did not have a screens in them.

Plan of Correction ***Accept (07/13/2023)***

The screen was replaced in #308 the day of inspection, 5-23-23. All other screens have been repaired/replaced by 6-2-23. EVS will continue to inspect windows and screens.

The screen in #308 was replaced by the Director of Environmental Services. The screens were replaced by EVS staff. Inspection began on 6-2-23 and will be continued monthly.

Licensee's Proposed Overall Completion Date: *07/06/2023*

Implemented (SQ - 09/08/2023)

101j7 - Lighting/Operable Lamp

5. Requirements

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

On 5/23/23 at 1:00 p.m., resident #1 did not have access to a source of light that could be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 07/13/2023)***

The light in question was mistakenly plugged into the wall socket that was operated by the wall switch. It has been addressed and the resident has been educated on the importance and the regulation regarding the operating light source at bedside. Housekeeping will monitor.

The light was plugged into a socket that is not operated by the light switch on 5-24-23 by the Administrator. The resident was educated on that day, 5-24-23, by the Administrator. Monitoring began the week of 6-5-23 and will continue weekly.

Licensee's Proposed Overall Completion Date: *07/06/2023*

Implemented ([redacted] - 09/08/2023)

103g - Storing Food

6. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 5/23/23 at 12:10 p.m., two 5-lb bags of cooked pasta were opened and uncovered in the cooler at the end of the serving table in the main kitchen.

On 5/23/23 at 12:15 p.m., two 5-lb bags of uncooked pasta were opened and uncovered on the shelf of the dry food storge room across from the main kitchen.

Plan of Correction ***Accept [redacted] - 07/13/2023)***

To ensure that all opened food items are sealed properly [redacted], dietary manager has purchased 2 vacuum sealers. [redacted] will in service staff on proper usage of vacuum sealers. The in-service will be on 6-19-23 and the sealers will be put to use after in-service is complete. [redacted] will also monitor and record weekly to ensure that all tems are dated, labeled, and sealed properly or put into plastic containers with a lid.

Monitoring began on 6-5-23.

Licensee's Proposed Overall Completion Date: *07/06/2023*

Implemented ([redacted] - 09/08/2023)

132c - Fire Drill Records

7. Requirements

2600.

132c - Fire Drill Records *(continued)*

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 drills conducted on 6/1/22 and 9/27/22, did not include the exit routes used, the number of residents in the home at the time of the drills, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detectors were operative.

Plan of Correction ***Accept (- 07/13/2023)***

The fire drills in question were training drills due to having Covid in the building. I have attached an amended fire drill record with the missing details. Environmental Director and I have discussed and reviewed proper documentation of fire drills and will ensure completion going forward.

The Administrator was educated onsite by DHS Licensing Representative, , on 5-24-23. The Administrator will continue to review all fire drill logs for completion. This began on 5-24-23 and will continue monthly.

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented (- 09/08/2023)

132e - Fire Drill Sleeping Hours

8. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home did not conduct a fire drill during sleeping hours between 1/1/22 and 7/31/22.

Plan of Correction ***Accept (- 07/13/2023)***

Fire drill requirements and regulations have been reviewed. I have attached the ongoing fire drill log to show sleeping hour drills are being done as needed. I will continue to monitor and update as needed.

Sleeping hour fire drills were held on 8-25-22 at 6:00am and again on 1-11-23 at 5:51am. The most recent was on 5-31-23 at 11:21pm.
The Administrator will oversee the fire drill records and will monitor monthly to ensure sleeping hours drills are being conducted. Monitoring began on 5-24-23.

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented - 09/08/2023)

141b1 - Annual Medical Evaluation

9. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation was completed on [redacted]

Plan of Correction ***Accept*** [redacted] ***- 07/13/2023)***

The resident in question is actually Resident #2. His medical evaluation was completed on 5-25-2023 and it is attached. The administrator and LPN will review all DME's monthly to ensure timely completion.

All resident charts were reviewed by the Administrator on 5-26-23. A calendar/list was made of all residents and the dates the most recent DME was completed. The Administrator will review the list monthly to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented ([redacted] ***09/08/2023)***

183d - Prescription Current

10. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 5/23/23 4:30 p.m., [redacted] *tablets for resident #3 were present in medication cart #1; however, there was no current prescriber's order for the medication. The current order was for* [redacted] *tablet 2x daily.*

On 5/23/23 4:30 pm, [redacted] *17 grams for resident #4 was present in medication cart #2; however, the prescriber's order for the medication was discontinued on* [redacted].

Repeat Violation: 5/10/22

Plan of Correction ***Accept (*** [redacted] ***- 07/13/2023)***

A med cart audit was completed on 5-23-23 and both medications were removed. The order for the [redacted] *was confirmed and the appropriate medication is in the cart. The* [redacted] *has been removed.*
Ongoing audits will be conducted weekly by overnight Med Tech staff. Additional oversite and monitoring will be completed by the LPN and the administrator.

The med cart audit was completed by the LPN and a med tech.
The LPN confirmed the order by calling the ordering Phyician's office and speaking to a nurse. This was done on 5-24-23.
The audits began on 5-24-23 and the oversite and monitoring began immediately on 5-24-23 as well and have been conducted bi-weekly.

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented [redacted] ***09/08/2023)***

184a - Resident's Meds Labeled

11. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 was prescribed [redacted] per the following sliding scale: 70-140 = 0 units, 141-180-1 unit, 181-220- 2 units, 221-260= 3 units, 261-300= 4 units, 301-340= 5 units, and >340= call MD. However, the pharmacy label on the medication did not indicate the sliding scale.

Resident #2 was prescribed of [redacted] tablets by mouth daily; however, the pharmacy label on the medication indicated- give 1000IU X2 tablets daily.

Resident #2 was prescribed [redacted] tablet by mouth X1 daily; however, the pharmacy label in the medication indicates twice per day.

Resident #2 was prescribed [redacted] eal and before bedtime per sliding scale: 70-140= 0, 141-180=3, 181-220= 6 units, 221-260= 9, 261-300 = 12, 301-340= 15, 341-400 = 16, 401-500 = 18. However, the pharmacy label on the medication did not indicate the sliding scale.

Resident #2 was prescribed [redacted] of 12 units daily; however, the pharmacy label on the medication indicated 16 units with 14 units also handwritten on the label.

Resident #3 was prescribed [redacted] tablets twice per day; however, the pharmacy label on the medication label indicates 1 tablet twice per day.

Repeat Violation: 5/10/22

Plan of Correction ***Accept [redacted] - 07/13/2023)***

Resident #1- [redacted] The sliding scale is now on the label, see attached picture.
Resident # [redacted] The pharmacy label has been corrected, see attached picture.
Resident # [redacted]) The order was changed by the physician to 2x daily. I have attached the updated DME with order and pharmacy label.
Resident #2- [redacted]) The pharmacy label has been updated to include the sliding scale. See attached photo.
Resident #2- [redacted]) The order was changed to 14 units. I have attached the residents DME to show the correct order is 14 units.
Resident #3 ([redacted] The pharmacy label reads " Take 2 tablets by mouth twice daily for 7 days. Then take 1 tablet twice daily". I have attached the order and the DME. We are following the correct instructions and dosage.

All the corrections have been made and both carts have been audited. All staff who handle medication have been reeducated about the need for proper labeling. This will be an ongoing process of education and oversite. Weekly med cart audits will include labeling reviews. Any new medications will be checked in by 2 staff members to ensure proper labeling and dosage.

184a - Resident's Meds Labeled (continued)

The corrective actions were completed by the med techs. All were included in the labeling for education purposes.
The corrections took place on 5-23-23.
The cart audits began on 5-24-23 and have been ongoing weekly since then.
Reeducation of staff was conducted by the Administrator and the LPN on 5-24-23 and 5-30-23.
The overnight cart audits began on 6-5-23 by a senior med tech.
The begin date for the 2 staff members new medication audit began immediately as well, 5-24-23.

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented ([redacted] - 09/08/2023)

185a Implement Storage Procedures

12. Requirements

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 #1 was prescribed [redacted] per the following sliding scale: 70-140 = 0 units, 141-180-1 unit, 181-220- 2 units, 221-260= 3 units, 261-300= 4 units, 301-340= 5 units, and >340= call MD. On multiple dates and times, to include the following, the resident's blood sugar readings indicated on the resident's glucometer were not documented on resident #1's May 2023 medication administration record (MAR):

[redacted]

Plan of Correction ***Accept [redacted] 07/13/2023)***

The glucometer has been calibrated and reset. I have attached a few pictures of the glucometer readings and the MAR to show the dates and times are in now in sync. All resident glucometers have been inspected and recalibrated as needed. This will be an ongoing process and monthly checks will be completed by the LPN and/or designee.

The immediate action was the EMAR was updated on 5-24-23 by the LPN to include blood sugar readings. We also discovered the glucometer needed to be recalibrated. It was updated by a Med Tech on 5-24-23 also. The Administrator educated the LPN and all Med Techs to include the blood sugar readings in the EMAR for all diabetic residents. We looked into all other diabetic MARs to ensure they were set up correctly to include blood sugar readings. The Administrator and the LPN conduct monthly audits of the MAR to ensure compliance.

185a - Implement Storage Procedures *(continued)*

Licensee's Proposed Overall Completion Date: *07/10/2023*

[redacted] ***- 09/08/2023)***

187a Medication Record

13. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1 was prescribed [redacted] *per the following sliding scale: 70-140 = 0 units, 141-180-1 unit, 181-220- 2 units, 221-260= 3 units, 261-300= 4 units, 301-340= 5 units, and >340= call MD. However, the resident's May 2023 medication administration record does not include the order for the sliding scale.*

Plan of Correction [redacted] ***07/13/2023)***

The EMAR was updated with the sliding scale as per the prescribing physician. Staff has been reeducated on the required information that needs to be recorded in the MAR. Ongoing, all new orders will be verified by 2 staff members to be sure all information is included. The 2 staff members will be the Med Tech/ LPN on duty and the ncoming (next shift) Med Tech/LPN. I have attached a copy of the updated MAR for this resident.

The EMAR was updated on 5-24-23 by the LPN.
The staff was reeducated on 5-24-23 by the administrator.
The 2 staff member verification began on 5-24-23 as well.

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented [redacted] ***- 09/08/2023)***

14. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

6. Dose.

187a - Medication Record *(continued)*

Description of Violation

Resident #1 was prescribed [redacted] unit per sliding scale: 70-140 = 0 units, 141-180-1 unit, 181-220- 2 units, 221-260= 3 units, 261-300= 4 units, 301-340= 5 units, and >340= call MD.

On multiple dates and times, the resident's blood sugar reading was taken, and the resident was administered the medication, including the following: [redacted]

However, the dose of the medication being administered was not documented on the resident#1's May 2023 medication administration record.

Plan of Correction ***Accept [redacted] - 07/13/2023)***

The EMAR was updated to enable the recording of amounts given when insulin is needed. I have attached a copy of the June MAR so far. I have educated staff regarding the importance of proper record keeping in the MAR.

The EMAR was updated on 5-24-23 by the LPN.
The Administrator educated the staff on 5-24-23 regarding the importance of proper record keeping in the MAR.
The Administrator is continuing to monitor the EMAR. Monitoring began as weekly but is now monthly as all record keeping has been up to date and complete.

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented (SQ - 09/08/2023)

225a Assessment 15 Days

15. Requirements

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

Description of Violation

Resident #3 was admitted on [redacted] however, the resident's assessment was not completed until [redacted]

Plan of Correction ***Accept ([redacted] 07/13/2023)***

The staff member responsible for completing the RASP's has been reeducated about the timeline and importance of completing the assessment in the timeframe requirement set by DHS. The LPN will continue to complete the initial assessment with the oversite of the administrator.

The initial RASPs will be completed by the LPN.
The Administrator reeducated the LPN on 5-26-23.
When a new resident moves in the LPN and the Administrator will discuss the timeline for completion of the RASP.
The Administrator will revisit the timeline 1 week after to ensure progress. Assistance will be given if needed by the Administrator.

225a - Assessment 15 Days (continued)

A designated med tech will complete the annual RASPs. Both the Administrator and LPN will provide oversite to ensure completion monthly. A list has been created with a monthly schedule. The Administrator will provide assistance and ensure the completion of the RASPs.

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented [redacted] - 09/08/2023)

225c - Additional Assessment

16. Requirements

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #1's assessment, dated [redacted] did not include an assessment of the resident's needs for securing and using transportation or making and keeping appointments. These sections of the form were blank.

Resident #2's most recent assessment was completed on [redacted]

Resident #4's assessment, dated 2/16/23, did not include an assessment of the resident's needs for managing healthcare, securing health care, and doing laundry. These sections of the form were blank.

Plan of Correction ***Accept ([redacted] - 07/13/2023)***

Additional education to the staff member completing the RASPs has been provided. Annual assessments and significant change assessments will be completed the LPN and designee. Ongoing education and reviews will be conducted by the administrator.
The assessments in question have been corrected and I are attached. The assessment for Resident #2 was completed but was unfortunately not present at the time of inspection.

The initial RASPs will be completed by the LPN.
The Administrator reeducated the LPN on 5-26-23 regarding the importance of completing the RASPs in it's entirety.
A designated med tech will complete the annual RASPs. Both the Administrator and LPN will provide oversite to ensure completion monthly. A list has been created with a monthly schedule. The Administrator will provide assistance and ensure the completion of the RASPs.

Licensee's Proposed Overall Completion Date: *07/10/2023*

Implemented ([redacted] - 09/08/2023)

227e - Self Administer Medication

17. Requirements

227e - Self Administer Medication *(continued)*

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident 1's assessment, dated [redacted] does not address the resident's ability to self-administer medications.

Plan of Correction ***Accept [redacted] - 07/13/2023)***

The staff member has been addressed and reeducated regarding the completion of all sections of the RASP. Oversite will be provided by the administrator to ensure the completion of all sections of the RASP. This RASP has been completed in its entirety and I have attached the page in question.

The initial RASPs will be completed by the LPN and the annual RASPs will be completed by a med tech. Any updates due to significant changes will be completed by the LPN.
The Administrator reeducated the LPN on 5-26-23 regarding the importance of completion of the entire RASP.
The oversite began immediately on 5-26-23 by the Administrator and will continue monthly.
The RASP was updated on 5-23-23 by the LPN.
The intial monitoring step was completed by the Administrator and the LPN on 5-26-23. We reviewed all RASPs of all residents for completion.
Ongoing monitoring will be conducted by the Administrator on a monthly basis. This began immediately on 5-26-23.

Licensee's Proposed Overall Completion Date: *07/10/2023*

Implemented ([redacted] - 09/08/2023)

251b - Record Entries Legible

18. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident #2's current medical evaluation completed [redacted] has illegible writing covering a previous entry in the section for date resident was evaluated, date form completed, and date the physician signed.

Plan of Correction ***Accept ([redacted] - 07/13/2023)***

A new DME for this resident was completed by [redacted] physician. It is attached here. All incoming DME's will be reviewed to completion and to ensure that it is legible. Any issues with the clarity will be addressed by contacting the person who completed the form. Any corrections or additions to the DME will be initialed by the person making the entry.

The new DME was completed on [redacted] The process for reviewing all DMEs began on 5-26-23 by the Administrator. A list was compiled of all residents and the dates of the most recent DME's. The Administrator will oversee this list and direct the LPN in ensuring completion. The Administrator and the LPN will discuss the list monthly and who will need to schedule a physician's exam to complete the DME. The Administrator has educated the LPN on the need for review all incoming DME's for completion. The LPN will review all incoming DME's before

251b - Record Entries Legible (continued)

filing to ensure completion. The Administrator will provide additional back up and will continue to randomly spot check DME's on a monthly basis. This oversite began 5-26-23.

Licensee's Proposed Overall Completion Date: *07/07/2023*

[redacted]***- 09/08/2023)***