



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **BRODHEAD SENIOR LIVING LLC**

LEGAL ENTITY

To operate **APPLE BLOSSOM SENIOR LIVING**

NAME OF FACILITY OR AGENCY

Located at **125 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA 15108**

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **150**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 5, 2023** until **November 5, 2023**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **450723**

[Signature]
ISSUING OFFICER

[Signature]
ACTING DEPUTY SECRETARY

NOTE This certificate is issued for the above site(s) only and is not transferable
and should be posted in a conspicuous place in the facility.

HS 628P – 04/23



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: May 12, 2023

[REDACTED]
Brodhead Senior Living LLC
125 Apple Blossom Way
Moon Township, Pennsylvania 15108

RE: Apple Blossom Senior Living
License/COC #: 450723

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on September 23, 2022, December 20, 2022, and December 21, 2022, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a THIRD PROVISIONAL license to operate the above facility. A THIRD PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed and is valid from May 5, 2023 to November 5, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
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Section:

85(a)	II	88	\$5	\$440	5 calendar days from mailing date of this letter
91	II	88	\$5	\$440	5 calendar days from mailing date of this letter
103(g)	III	88	\$3	\$264	15 calendar days from mailing date of this letter
132(c)	II	88	\$5	\$440	5 calendar days from mailing date of this letter
132(d)	II	88	\$5	\$440	5 calendar days from mailing date of this letter
183(e)	II	88	\$5	\$440	5 calendar days from mailing date of this letter
184(a)	II	88	\$5	\$440	5 calendar days from mailing date of this letter
184(b)	II	88	\$5	\$440	5 calendar days from mailing date of this letter
185(a)	II	88	\$5	\$440	5 calendar days from mailing date of this letter
187(a)	II	88	\$5	\$440	5 calendar days from mailing date of this letter
187(d)	II	88	\$5	\$440	5 calendar days from mailing date of this letter
225(a)	II	88	\$5	\$440	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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

Facility Information

Name: *APPLE BLOSSOM SENIOR LIVING* License #: *45072* License Expiration: *03/07/2023*
Address: *125 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA 15108*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *BRODHEAD SENIOR LIVING LLC*
Address: *125 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA, 15108*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *08/27/2019* Issued By: *Moon Twp.*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *135* Waking Staff: *101*

Inspection Information

Type: *Partial* Notice: *Announced* BHA Docket #:
Reason: *Fine* Exit Conference Date: *09/23/2022*

Inspection Dates and Department Representative

09/23/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* Residents Served: *89*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *89*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *46* Have Physical Disability: *0*

Inspections / Reviews

09/23/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *10/07/2022*

10/07/2022 - POC Submission

Submitted By: [REDACTED] Date Submitted: 10/27/2022

Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/13/2022

10/11/2022 - POC Submission

Submitted By: [REDACTED] Date Submitted: 10/27/2022

Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 10/27/2022

04/14/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: 10/27/2022

Reviewer: [REDACTED] Follow-Up Type: Enforcement

183d - Prescription Current**1. 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

Resident #1 was prescribed Icosapent 1 gm-Take 2 capsules by mouth 2 times daily. This medication was discontinued on 8/29/22; however, was still present in the home's medication cart.

Resident #1 was prescribed Polyethylene Glycol-Mix 17 gm in 8 ounces of water and drink by mouth once daily. This medication was discontinued on 8/22/22; however, was still present in the home's medication cart.

Resident #2 was prescribed Famotidine 20 mg tablet-Take 1 tablet by mouth 2 times a day. This medication was discontinued on 8/8/22; however, was still present in the home's medication cart.

POC Submission**Directed** [REDACTED] **10/11/2022)**

10/7/2022 the Nurse/Med Tech shall complete both a MAR audit and Med Cart Audit once per week for 1 month and then once monthly routinely for all residents to ensure that all currently prescribed medications are available and to review all medication pharmacy and OTC labels to ensure accuracy in accordance with prescriber's orders. The Nurse/Med Tech will review the medications for all current residents to ensure that all medications are present and available in accordance with prescriber's orders. Documentation of audit will be kept. Additionally, by 10/27/2022 all staff who are qualified to administer medications will be educated on the re-ordering procedures and what to do when medications are running low. (DIRECTED: Documentation of the education shall be kept. [REDACTED] 10/11/22).

Additionally, Resident #1's Icosapent 1gm was removed from the cart on 9/23/2022.

Resident #1's Polyethylene Glycol-Mix 17 gm was removed from the med cart on 9/23/2022.

Resident #2's Famotidine 20 mg Tablet was removed from the cart on 9/23/2022.

Directed Completion Date: 10/27/2022**Not Implemented** [REDACTED] **12/22/2022)****184a - Resident's Meds Labeled****2. Requirements**

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #1's pharmacy label indicates Gabapentin 100 mg-Take 2 capsules by mouth 2 times daily; however,

184a - Resident's Meds Labeled (continued)

resident #1 is prescribed Gabapentin 100 mg-Take 2 capsules by mouth once daily.

No pharmacy labels are present on the following medications for resident #3:

- *Losartan Potassium-50 mg tablet*
- *Myrbetriq ER-25 mg tablet*

Resident #4's pharmacy label indicates Hydrocortisone 5 mg tablet-Take 2 tablets by mouth each day and 1 tablet at bedtime; however, resident #4 is prescribed Hydrocortisone 10 mg tablet-Take 1 tablet by mouth every morning after breakfast and Hydrocortisone 5 mg tablet-Take 1 tablet by mouth every evening.

REPEAT VIOLATION: 7/7/2022; 3/23/2022, et. al.

POC Submission

Directed (█████-10/11/2022)

By 10/7/2022 the Nurse/Med Tech shall complete both a MAR audit and Med Cart Audit once per week for 1 month and then once monthly routinely for all residents to ensure that all currently prescribed medications are available and to review all medication pharmacy and OTC labels to ensure accuracy in accordance with prescriber's orders. The Nurse/Med Tech will review the medications for all current residents to ensure that all medications are present and available in accordance with prescriber's orders. Documentation of audit will be kept. Additionally, by 10/27/2022 all staff who are qualified to administer medications will be educated on the re-ordering procedures and what to do when medications are running low. (DIRECTED: The education shall also include the home's procedures for updating resident pharmacy labels upon receipt of new orders from the physician. Documentation of the education shall be kept. █████10/11/22).

Additionally, Resident #1's Gabapentin 100 mg Capsules label was corrected on 9/23/2022. Resident #3's Losartan Potassium 50 mg Tablet and Myrbetriq ER 25 mg Tablet labels were placed on the medication on 9/23/2022. Resident #4's Hydrocortisone 5 mg tablet label was corrected on 9/23/2022.

Directed Completion Date: 10/27/2022

Not Implemented (█████-12/22/2022)

184b - Labeling OTC/CAM**3. Requirements**

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

A unlabeled bottle of D Mannose-500 mg tablet, belonging to resident #3, was present in the home's medication cart.

An unlabeled bottle of Vitamin D3-25 mcg and an unlabeled bottle of aspirin-81 mg, both belonging to resident #5, were present in the home's medication cart.

REPEAT VIOLATION: 3/23/2022, et. al.

184b - Labeling OTC/CAM (continued)

POC Submission

Directed [REDACTED] 10/11/2022)

10/7/2022 the Nurse/Med Tech shall complete both a MAR audit and Med Cart Audit once per week for 1 month and then once monthly routinely for all residents to ensure that all currently prescribed medications are available and to review all medication pharmacy labels to ensure accuracy in accordance with prescriber's orders. The Nurse/Med Tech will review the medications for all current residents to ensure that all medications are present and available in accordance with prescriber's orders. Documentation of audit will be kept. (DIRECTED: The weekly and monthly cart audits shall also include a review of all OTC medications and CAM's belong to residents to ensure they are labeled with the residents' names. [REDACTED] 10/11/22). Additionally, by 10/27/2022 all staff who are qualified to administer medications will be educated on the re-ordering procedures and what to do when medications are running low. (DIRECTED: The education shall also include ensuring that all OTC medications and CAM's belonging to residents are labeled with the residents' names. Documentation of the education shall be kept. [REDACTED] 10/11/22). Additionally, Resident #3's unlabeled bottle of D Mannose-500mg Tablet was correctly labeled on 9/23/2022. Resident #5's Vitamin D3-25 mcg and Aspirin 81 mg were correctly labeled on 9/23/2022.

Directed Completion Date: 10/27/2022

Not Implemented [REDACTED] 12/22/2022)

185a - Implement Storage Procedures

4. 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 is prescribed blood sugar checks once daily in the morning. On 9/22/22 at approximately 6:00 AM, resident #1's blood sugar was 259; however, this blood sugar reading was documented as 244 on resident #1's September 2022 medication administration record (MAR).

REPEAT VIOLATION: 7/7/2022; 3/23/2022, et. al.

POC Submission

Directed [REDACTED] 10/11/2022)

By 10/7/2022 The Nurse/Med Tech shall complete both a MAR audit and Med Cart Audit once per week for 1 month and then once monthly routinely for all residents to ensure that all currently prescribed medications are available and to review all medication pharmacy labels to ensure accuracy in accordance with prescriber's orders. Also, resident glucometers will be checked to ensure that they are appropriately calibrated during this audit.

DIRECTED: Beginning on 10/15/22: A staff person qualified to administer medications shall audit the MAR's and glucometers for all residents prescribed blood sugar checks and insulin administration weekly for 2 months then monthly thereafter to ensure all blood sugars are taken in accordance with prescribers' orders and are accurately documented on resident MAR's. Documentation of the audits shall be kept. [REDACTED] 10/11/22

Record will be kept on file. Additionally, by 10/27/2022, all staff will be in-serviced on proper documentation

185a - Implement Storage Procedures (continued)

procedure for vitals, including blood sugar readings in the EMR. (DIRECTED: Documentation of the education shall be kept. [REDACTED] 10/11/22),

Directed Completion Date: 10/27/2022

Not Implemented [REDACTED] - 12/22/2022)

187a - Medication Record**5. 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).

Description of Violation

Resident #1's September 2022 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- Acetaminophen-500 mg tablet
- Aspirin-81 mg tablet
- Atorvastatin-20 mg tablet
- Irbesartan-75 mg tablet
- Potassium Chloride-10 meq tablet
- Repaglinide-1 mg tablet
- Stimulant-8.6 mg\50 mg tablet

Resident #2 is prescribed Acetaminophen suppositories 650 mg- Insert 1 suppository rectally every 4 hours as needed for moderate pain; however. this medication is not on resident #2's September 2022 MAR.

Resident #3's September 2022 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- Pantoprazole Sodium-40 mg tablet
- Simvastatin-40 mg tablet
- Xeljanz-5 mg tablet

REPEAT VIOLATION: 7/7/2022; 3/23/2022, et. al.

187a - Medication Record (continued)

POC Submission

Directed (████) 10/11/2022)

On 9/27/2022, a complete audit of all resident medication records was performed and all medication orders were confirmed to include the following: Resident Name, Drug allergies, Name of medication, strength, Dosage form, Dose, Route of administration, Frequency of administration, Administration times, Duration of therapy, if applicable, Special precautions, if applicable and Diagnosis or purpose for the medication, including pro re nata (PRN). Additionally, this audit will be performed once monthly routinely starting on 10/11/2022 for all residents to ensure that all records are properly updated and maintained. (DIRECTED: Documentation of the audits shall be kept. █████ 10/11/22)

DIRECTED: By 10/27/22: All staff persons qualified to administer medications shall be educated on the home's procedures for updating resident MAR's upon receipt of a new/change order issued by the prescriber. Documentation of the education shall be kept. █████ 10/11/22

Directed Completion Date: 10/27/2022

Not Implemented (████) 12/22/2022)

187d - Follow Prescriber's Orders

6. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 9/20/22, resident #3 was prescribed Macrobid 100 mg-Take 1 capsule by mouth daily. This medication has not administered to resident #3 since it was prescribed, because it is not available in the home for administration.

REPEAT VIOLATION: 3/23/2022, et. al.; 12/27/2021

POC Submission

Directed (████) 10/11/2022)

The root cause of the violation is that the Pharmacy was bough out by another company and we have had ongoing issues getting medications delivered in a timely manner. After having multiple conversations with Polaris Pharmacy with no results, Apple Blossom has decided to stop working with Polaris Pharmacy on January 1, 2023 and begin working with a new Pharmacy in an effort to eliminate the ongoing issues with Pharmacy deliveries. 10/7/2022 the Nurse/Med Tech shall complete both a MAR audit and Med Cart Audit once per week for 1 month and then once monthly for all residents to ensure that all currently prescribed medications are available and to review all medication pharmacy and OTC labels to ensure accuracy in accordance with prescriber's orders. The Nurse/Med Tech will review the medications for all current residents to ensure that all medications are present and available in accordance with prescriber's orders. Documentation of audit will be kept. Additionally, by 10/27/2022, all staff who are qualified to administer medications will be educated on the re-ordering procedures and what to do when medications are running low. (DIRECTED: Documentation of the education shall be kept. █████ 10/11/22). Additionally, Resident #3's Macrobid 100 mg Capsule was received on 9/21/2022 and administration began according to prescriber's orders immediately. (DIRECTED: Within 48 hours of receipt of the plan of correction. A designated staff person shall inspect the home's medication storage areas to ensure resident #3's Macrobid is

187d - Follow Prescriber's Orders (continued)

present in the home and available for administration. [REDACTED] 10/11/22).

Directed Completion Date: 10/27/2022

Not Implemented [REDACTED] 12/22/2022)

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

Facility Information

Name: *APPLE BLOSSOM SENIOR LIVING* License #: *45072* License Expiration: *03/07/2023*
Address: *125 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA 15108*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *BRODHEAD SENIOR LIVING LLC*
Address: *125 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA, 15108*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *08/27/2019* Issued By: *Moon Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *112* Waking Staff: *84*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Fine* Exit Conference Date: *12/21/2022*

Inspection Dates and Department Representative

12/20/2022 - On-Site: [REDACTED]
12/21/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* Residents Served: *88*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *88*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *24* Have Physical Disability: *0*

Inspections / Reviews

12/20/2022 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *01/13/2023*

01/23/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *02/05/2023*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *01/30/2023*

01/30/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *02/05/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *02/06/2023*

04/14/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *02/05/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

17 - Record Confidentiality

1. Requirements

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

On 12/20/22 At 1:06 p.m., a white binder with a handwritten note on the front of it indicated "Please do not change assignment sheets or floors assigned to unless approved by charge nurse or Diane or head med tech for the shift! TY" and contained confidential information on multiple residents that was unlocked, unattended and accessible across from the chapel at the first floor nurse's station counter, to include:

Glucometer Calibration & Coverage Dose (If Needed)

Date: 7/15/22

Resident Time Reading Units

Resident #1 12:00 p.m. 255 9 units

Resident #2 8:00 a.m. 287 6+3 = 9 units

Resident #2 12:00 p.m. 209 32 Lantus4 units+5 = 9 units

The binder also contained physician's orders dated 6/20/22 for resident #3 that contained instructions to discontinue current Carvedilol orders, begin new Carvedilol orders, take 12.5mg by mouth twice daily and hold if systolic blood pressure less than 100, blood pressure and heart rate checks twice daily for seven days, to check comprehensive blood count and basic metabolic panel on Monday, to please check on Xarelto dosing, and to do weekly weight tests four times beginning on 6/20/22.

On 12/20/22 at 1:45 p.m. there was a folder labeled Blood Glucose Tracker in the bottom desk drawer to the left of the computer in the first floor nurses station across from the chapel and the folder included paperwork with the names and dates of birth for resident #4 and resident #5.

Plan of Correction

Accept [REDACTED] 01/30/2023)

12/20/22 - Both binders were removed from the 1st floor care base during the survey. The med tech who was responsible for leaving the binders unsecured was coached at that time.

1/3/2023 - Med Techs were re-trained on the regulation that resident information must be secured and kept confidential except in emergencies. A documented record of training was signed by staff and will be submitted after POC is accepted.

1/13/2023 Responsible: Executive Director. A plan has been approved to move the open care base on the 1st flr. (where the binders were found) to a enclosed room that can be locked when the med tech's are on the floor. Resident information will be kept inside this locked room. Executive Director will inspect open care base 2X daily during the building walk through until the area can be relocated to the enclosed area. Executive Director will monitor entire facility 2X per day to verify that all documents with resident identifiable information is kept confidential and available only to staff for the purpose of providing services to the resident, the resident, the resident responsible party, agents of the Dept and the county ombudsman.

Licensee's Proposed Overall Completion Date: 01/29/2023

17 - Record Confidentiality (continued)

Not Implemented (██████ 04/14/2023)

25a - Written Contract and Review

2. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

There is no resident-home contract for resident #6, admitted ██████

Plan of Correction

Accept (██████ 01/30/2023)

1-3-2023 - Executive Director met with resident #6 and explained to resident that when ██████ moved from ██████ into ██████ that ██████ should have been asked to sign a resident agreement for PC.

1-3-2023 Executive Director verified with resident the date ██████ moved into PC. At that time the new resident contract was reviewed with resident and she acknowledged the appropriate papers that required her signature. PC contract was placed in resident file. A copy of Resident#6 acknowledgment will be submitted after POC is accepted.

1-12-2023 Executive Director will be present at all lease signing with new residents. ED will be responsible to verify that the correct contract is completed and signed by the resident. Executive Director has reviewed all resident records and verified that each resident has a resident home contract between the resident and the home in place.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented (██████ 04/14/2023)

41e - Signed Statement

3. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

There is no signed statement in resident #6's resident record acknowledging the receipt of a copy of the resident's rights and complaint procedures.

Plan of Correction

Accept (██████ 01/30/2023)

1-3-2023 - Executive Director met with resident #6 and explained to resident that when ██████ moved from ██████ into ██████ that ██████ should have been asked to sign a resident agreement for PC that included the Resident Rights and the complaint procedures..

1-3-2023 - Resident #6 signed the PC residency agreement acknowledging her copy of the agreement. A copy of the Resident Rights and complaint procedure is included in the home contract. A copy of this acknowledgment will be submitted after the POC is accepted.

1-13-2023 Executive Director has reviewed all resident records and verified all residents have a PC contract in

41e - Signed Statement (continued)

their resident file. The resident contract between the resident and the home includes a copy of the Resident Rights and the complaint procedure. Executive Director will be responsible to ensure all new residents moving in after 1-13-2023 have a PC Residency Agreement in the resident file.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented [REDACTED] **04/14/2023)**

81b - Resident Personal Equipment**4. Requirements**

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 12/20/22 at approximately 1:00 p.m. there was a U-shaped enabler bar on left side of bed in resident room #112 belonging to resident #7 that had an opening measuring approximately eight inches high by six inches wide and presented a risk of limb entanglement for resident #8, who sleeps in resident room #112 from time to time on the left side of the bed.

Plan of Correction

Accept [REDACTED] **01/30/2023)**

1/6/2023- Family of resident #7 contacted since they supplied the bed cane for resident #8. Family of resident #7 uncooperative with being in compliance and refused to replace device. Executive director purchased a bed cane that included a cover and had housekeeping supervisor install new device.

1/6/23 - LPN visited every room and documented rooms with bed canes that did not have covers. Any room identified as needing a cover for a bed cane, families were contacted and families replaced the bed cane that had a cover installed to prevent entrapment. Executive Director met with Fox Therapy group so they understood the regulation and what is acceptable as far as bed canes.

1/12/23 - Nursing dept will be responsible to verify with therapy when a bed cane is suggested that it meets regulation. Nursing will notify families if they notice a bed cane that does not have a cover and follow through to ensure a cover is intact. Any resistance from families will be handled by the Executive Director.

1/26/2023 Housekeeping Supervisor and/or Maintenance Director will monitor the placement of any bed canes, verify covers are intact and secured within the facility 1X weekly. A compliance checklist will be documented and maintained to verify weekly monitoring. A copy of this checklist will be submitted after POC is accepted.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented [REDACTED] **04/14/2023)**

82a - Poisonous Materials**5. Requirements**

2600.

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

Description of Violation

On 12/20/22 at approximately 12:56 p.m. there were two thirty-two fluid ounce spray bottles, one each of Odor Ban

82a - Poisonous Materials (continued)

and Mr. Clean cleaning solutions that were found on the home's cleaning cart in front of resident room # [REDACTED] belonging to resident #9, and not stored in their original labeled containers. There was also a plastic cylinder with a toilet brush and a dark green liquid which staff identified as a low acid bowl cleaner on the same cart in front of resident room [REDACTED] belonging to resident #9.

Plan of Correction**Accepted** [REDACTED] 01/30/2023)

12/23/2022 - Housekeeping supervisor marked all unlabeled containers on the housekeeping carts so the contents inside were clearly identified.

1/7/2023 - Housekeeping supervisor in-serviced the housekeepers on 2600.82a. reminding them that all containers used for housekeeping must be labeled with the original mfg. label to identify the contents.

1/27/2023 - Housekeeping supervisor will inspect all housekeeping carts weekly to ensure all bottles on the housekeeping cart are stored in their original containers and that the labels are intact and readable.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented [REDACTED] - 04/14/2023)**85a - Sanitary Conditions****6. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 12/21/22 at approximately 9:35 a.m. there were multiple splatter marks of dried yellow and purple substances of unknown origin on the bottom right side of the home's Hoshizaki commercial series cooler to the left of the delivery access door to the home's kitchen.

REPEAT VIOLATION 3/23/2022, et. al.

Plan of Correction**Accepted** [REDACTED] 01/30/2023)

12/21/2022 - Executive Chef wiped spill off the bottom of the cooler when identified by the Dept. inspector.

12/21/2022 - Executive Chef met with dietary staff and reminded them of the importance of wiping spills when they happen and not leaving them until the end of day cleaning.

1/27/2023 - Executive Chef posted in the kitchen a reminder about cleaning spills when they happen in addition to the cleaning requirements that were already posted and are required daily. Executive Chef will be responsible for daily monitoring of the kitchen. Maintenance/Housekeeping supervisors will monitor all public areas of the facility 1X daily for unsanitary conditions and ensure any issues are corrected immediately.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented [REDACTED] 04/14/2023)**91 - Telephone Numbers**

7. 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 12/20/22 at 12:34 p.m. the required emergency telephone numbers not posted on or near the telephones in the living area or bedroom of resident room [REDACTED] belonging to resident #6.

On 12/20/22 at 12:20 p.m. the required emergency telephone numbers not posted on or near the telephone in the living area or bedroom of resident room [REDACTED] belonging to resident #10 and resident #11.

REPEAT VIOLATION 3/23/2022, et. al.

Plan of Correction

Accept [REDACTED] - 01/23/2023)

1/3/2023- Housekeeping supervisor visited every room to verify what rooms were missing emergency phone numbers by and/or on their personal phones.

1/4/2023- Housekeeping supervisor replaced all emergency phone number stickers that were missing from residents personal phones that were identified by the room by room check. [REDACTED] also explained to all residents the purpose and regulation for keeping these numbers intact on their phones.

1/12/2023 Housekeeping supervisor will 1X monthly conduct a room by room check to verify the phone number stickers have not been removed and are still legible. The move in coordinator will educate new residents of the need for keeping the phone number stickers on their phones after move in.

Licensee's Proposed Overall Completion Date: 01/12/2023

Not Implemented [REDACTED] - 04/14/2023)

95 - Furniture and Equipment**8. Requirements**

2600.

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

Description of Violation

On 12/20/22 at 11:35 a.m., the motion sensor water faucet in the third-floor common women's restroom across from resident room [REDACTED] belonging to resident #12 and near the theater room is not operational, the water will not turn on.

Plan of Correction

Accept [REDACTED] 01/23/2023)

12/30/2022- Housekeeping supervisor replaced the battery that operates the automatic faucet in the ladies rest room on the third floor.

1/4/2023- Housekeeping supervisor replaced all the batteries in all the automatic faucets on all three floors. The original faucet that was not working properly failed again and was replaced by a non-automatic faucet as an immediate fix to keep that public restroom operational. All faucets are fully operational in the facility.

1/12/2023 - Housekeeping supervisor will 1X monthly check all faucets to ensure batteries have not failed. Batteries will be replaced proactively every 6 mths in all automatic faucets.

Licensee's Proposed Overall Completion Date: 01/12/2023

95 - Furniture and Equipment (*continued*)*Not Implemented* - 04/14/2023)

101j7 - Lighting/Operable Lamp

9. 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 12/20/22 at 11:20 a.m. there was no operable source of light at bedside in resident room [REDACTED] belonging to resident #12.

On 12/20/22 at 12:20 p.m. there was no operable source of light at bedside in resident room [REDACTED] belonging to resident #11 and resident #10 the lamp was unplugged and the light bulb was not in working order.

Plan of Correction*Accept* (- 01/23/2023)

12/21/2022- Housekeeping supervisor replaced the bulb in the bedside lamp of resident #12 while Dept. Inspector was still in the room. The bedside lamp belonging to resident # 11 & #10 [REDACTED] was removed from dresser and put back on night stand and bulb replaced. Residents did not want it there and unplugged it and put it back on the dresser. Puck lights were placed beside the bed as a light source for these residents.

1/5/2023 - Housekeeping supervisor conducted a room by room inspection to identify any rooms where a bedside lamp was not in place. A puck light was placed beside the bed as a source of light for those residents.

1/12/2023 - Housekeeping will check each bedside light source 1X weekly during the routine cleaning of the room. Light bulbs will be replaced as needed. Puck lights will be installed if a resident chooses not to have a bedside lamp.

Licensee's Proposed Overall Completion Date: 01/12/2023

Not Implemented - 04/14/2023)

103g - Storing Food

10. Requirements

2600.

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

Description of Violation

On 12/21/22 at approximately 9:35 a.m. there were sixteen mini chocolate custard pies that were found uncovered on a half sheet tray in the home's Hoshizaki commercial series cooler to the left of the delivery access door to the home's kitchen.

REPEAT VIOLATION 3/23/2022, et. al.

103g - Storing Food (continued)

Plan of Correction

Accept [REDACTED] - 01/23/2023)

12/21/2022 - Executive Chef covered the deserts when identified by the Dept. Inspector.

12/22/2022 - Executive chef met with the dietary staff to educate and remind them of the importance of covering food in the holding cooler prior to being served at mealtime.

1/12/2023 - Executive Chef will inspect coolers daily to ensure all food being held for the next meal time is covered and dated.

Licensee's Proposed Overall Completion Date: 01/12/2023

Not Implemented [REDACTED] 04/14/2023)

132b - Safety Inspection/Fire Drill

11. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The most recent fire safety inspection and fire drill conducted by a fire safety expert is dated 11/30/21.

Plan of Correction

Accept [REDACTED] 01/23/2023)

12/21/2022- A letter from the fire safe expert was in place through 11/20/2022. A annual fire drill had been scheduled for 12/27/2022.by the previous administration.

12/27/2022- A supervised fire drill was conducted by the fire safety expert on

12/27/2022. A letter verifying this drill and the evacuation time established through 12/2023 was obtained and is on file at the facility. The fire drill conducted by the safety expert was within the evacuation time established. A copy of this letter will be submitted after POC is accepted.

1/12/2023 - A supervised fire drill will be conducted annually and has be pre-scheduled for 12/2023 with the same fire safety expert. . A copy of the annual inspection and established evacuation times will be kept on file along with the monthly fire drill log. Maintenance and Housekeeping supervisors are responsible for scheduling these drills and maintaining the files.

Licensee's Proposed Overall Completion Date: 01/12/2023

Implemented [REDACTED] - 04/14/2023)

132c - Fire Drill Records

12. Requirements

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

On 1/11/22 at 1:15 the home conducted a fire drill. However, the fire drill record does not indicate a.m. or p.m. for

132c - Fire Drill Records (continued)

the time of the drill, does not indicate the evacuation routes used, or the number of residents in the home at the time of the drill.

On 2/26/22 at 3:05 p.m. the home conducted a fire drill. However, the fire drill record does not indicate the number of residents in the home at the time of the drill or the evacuation routes used.

REPEAT VIOLATION 3/23/2022, et. al.

Plan of Correction

Accept [REDACTED] **01/30/2023)**

12/21/2022 - The fire drill log used in 1/2022 and 2/2022 was a corp. log not the log established by the Dept. 3/1/022 the Dept log was being used through 12/2022 and is documented with the date/time/evacuation route/number of residents evacuated.

12/27/2022 - A supervised fire drill by a fire safety expert was conducted and documented on the Dept. recommend fire drill log. Date/time/evacuation route/number of residents evacuated is documented on the log. A copy of this log will be submitted after POC is accepted.

1/27/2023 Maintenance and Housekeeping supervisors will be responsible for conducting monthly fire drills and will document the details of these drills on the Dept. recommended log. A copy of this log will be kept on file along with the documentation from the fire safety expert. Executive Director will monitor the log monthly after the monthly drill is conducted to ensure date/time/exits used are documented as well as the number of residents evacuated and the number of staff participating in the evacuating of residents to the safe zones in the facility.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented [REDACTED] **04/14/2023)**

132d - Evacuation**13. Requirements**

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 11/23/22 at 3:05 p.m. the home conducted a fire drill in eight minutes and thirty-six seconds with 86 residents in

132d - Evacuation (continued)

the home. However, the fire safety expert specified a safe evacuation time of eight minutes and no seconds on 11/30/21. During this same fire drill 86 residents were present in the home. However, only 82 residents were evacuated to a public thoroughfare or fire safe area designated in writing by a fire safety expert.

REPEAT VIOLATION 3/23/2022, et. al.

Plan of Correction**Accept (████ 01/30/2023)**

12/27/2022- Executive Director conducted a training session for staff prior to the supervised fire drill conducted by the fire safety expert. Addressed was the need to make sure all residents were evacuated at the safe zone before calling in the clear for their floor. No problems were identified during the supervised drill. A copy of this training will be submitted when the PO is accepted.

11/23/2022 Executive Director met with the residents who were refusing to evacuate during this monthly drill, which is why we were not in compliance with our evacuation time. No problems were identified during the 12/27 supervised drill.

1/12/2023 - Maintenance Director/Housekeeping Supervisor/Executive Director will verify that all residents are indeed located at the safe areas prior to calling the all clear during the monthly fire drills. Executive Director will meet with the responsible party and the resident that refused to participate in the monthly drill within 24hrs of the non participation. Any resident that refuses again will be given a notice to discharge due to violation of home rules described within the resident home contract. Fire drill logs will be monitored monthly by the Executive Director.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented (████ 04/14/2023)**132e - Fire Drill Sleeping Hours**

141a - Medical Evaluation

15. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #4 was admitted to the home on [REDACTED] however, the resident's initial medical evaluation is dated 3/17/21.

Resident #7 was admitted to the home on [REDACTED] however, the resident's initial medical evaluation is dated 10/25/21.

Resident #11 was admitted to the home on [REDACTED] however, the resident's initial medical evaluation is dated 10/14/22.

Plan of Correction

Accept [REDACTED] - 01/30/2023)

12/21/2022 - Executive Director conducted a thorough search of all files trying to locate the DME's that would have been in the timeframe for compliance.

12/26/2022 - Executive Director started conducting an internal audit and assembling resident files for all current residents. This project was completed on 1/6/2023.

1/12/2023 - Executive Director has put a process in place to ensure all new admission documentation and resident files are completed within the time frames that are required to maintain compliance. Marketing Director, Move in Coordinator and Executive Director will ensure this process is followed compliance is maintained.

.(accepted)

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented [REDACTED] 04/14/2023)

183b - Meds and Syringes Locked

16. Requirements

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

On 12/20/22 at 11:51 a.m. resident #13's medications were found unlocked, unattended, and accessible on resident #13's bathroom vanity countertop in resident room #340 to include Levothyroxine 112mcg tablet, Sertraline 100mg tablet, OxyCODONE 10mg tablet, Ondansetron 5mg tablet, Loperamide 2mg tablet, Diphen/Atrop 2.5mg tablet, and Clonazepam 0.5mg tablet, as well as over-the-counter medication to include a five hundred count bottle of Equate Ibuprofen 200mg tablets.

Plan of Correction

Accept [REDACTED] - 01/23/2023)

12/21/22 LPN spoke to Resident #13 and advised [REDACTED] that when [REDACTED] leaves [REDACTED] room that [REDACTED] door must be locked so [REDACTED] meds are secured. [REDACTED] was advised that the Executive Director will supply a lock box for her if [REDACTED] does not

183b - Meds and Syringes Locked (continued)

have one.

12/30/2022 A lock box was supplied to resident #13.

1/4/2023 - Executive Director spoke to the residents during resident council reviewing the guidelines for self administering medications.

1/13/2023 LPN went to each resident room that self administers medications and reeducated them on managing and securing their medications. She reviewed their medications with them as well. A copy of the resident acknowledgment of education will be submitted when POC is accepted.

1/13/2023 - LPN will visit each resident room that self administers medications, 1X month to make sure medications are secured and resident is taking medications as prescribed.

Licensee's Proposed Overall Completion Date: 01/13/2023

Not Implemented (■■■■) 04/14/2023

183e - Storing Medications**17. Requirements**

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #5's Basaglar Kwikpen 100 Units/ML expired on 12/6/22, however on 12/20/22 at approximately 3:43 p.m. the medication was located on the home's first floor medication cart.

REPEAT VIOLATION 7/7/2022

Plan of Correction

Accept (■■■■) 01/30/2023

12/20/2022- Expired medications were removed from the cart by med tech while LPN and Dept. Inspectors were present.

1/6/2023 LPN re-educated med techs on identifying and removing expired and discontinued medications from the cart

1/13/2023- LPN will perform med cart audits weekly. for the next 6 months. After that timeframe med cart audits will be reduced to monthly if previous audits remain consistently compliant. A copy of the med cart audits will be submitted after POC is accepted.

.(accepted)

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented (■■■■) 04/14/2023

184a - Resident's Meds Labeled**18. Requirements**

184a - Resident's Meds Labeled (continued)

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

There is no pharmacy label for Resident #5's Novolog Kwikpen 100 Units/ML – Give 3 units sub-Q before meals three times daily if BG is below 70 hold all insulin and use orange juice/sugar-recheck in 30. Continue to hold insulin. Then refer to sliding scale three times daily before meals; 70-140=0UN; 141-180=1UN; 181-220=2UN; 221-260=3UN; 261-300=4UN; 301-340=5; 341-380=6; 381-420=7 > 420=11 Call MD.

REPEAT VIOLATION 9/23/22; 7/7/2022; 3/23/2022, et. al.

Plan of Correction

Accept [REDACTED] - 01/30/2023)

12/20/2022- Insulin pens were put back into the pharmacy bag that contained the pharmacy label while the LPN and Dept Inspectors were present..

1/6/2023 LPN reeducated med techs on the importance of not removing the pens from the packaging that contains the original pharmacy label that includes the directions.

1/13/2023 LPN has been checking the insulin original packaging during her weekly med cart audits. No other incidents have been noted on the med cart audits since 12/20. Weekly med cart audits will continue through June 2023.

1/26/2023 All Med techs and nurses were re-educated on the homes policy and procedure for medication administration. DON will be responsible for monitoring med techs and nurses for compliance weekly. Weekly med cart audits will continue. A copy of the documented training will be submitted after POC is accepted.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented [REDACTED] - 04/14/2023)

185a - Implement Storage Procedures**19. 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 #5's medication administration record indicated a blood glucose reading of 95 mg/dL on 12/15/22 at 4:30 p.m. However, resident #5's Libre FreeStyle glucometer indicated a reading of 98 mg/dL on 12/15/22 at 4:13 p.m.

Resident #5's medication administration record does not indicate a blood glucose reading on 12/15/22 at 6:00 p.m. However, resident #5's Libre FreeStyle glucometer indicated a reading of 281 mg/dL on 12/15/22 at 6:03 p.m.

Resident #5's medication administration record does not indicate a blood glucose reading on 12/15/22 at 8:00 p.m. However, resident #5's Libre FreeStyle glucometer indicated a reading of 339 mg/dL on 12/15/22 at 8:07 p.m.

185a - Implement Storage Procedures (continued)

Resident #5's medication administration record does not indicate a blood glucose reading on 12/16/22 at 7:00 p.m. However, resident #5's Libre FreeStyle glucometer indicated a reading of 201 mg/dL on 12/16/22 at 7:14 p.m.

Resident #5's medication administration record does not indicate a blood glucose reading on 12/18/22 at 9:00 p.m. However, resident #5's Libre FreeStyle glucometer indicated a reading of 217 mg/dL on 12/18/22 at 8:55 p.m.

Resident #5's medication administration record does not indicate a blood glucose reading on 12/19/22 at 6:00 p.m. However, resident #5's Libre FreeStyle glucometer indicated a reading of 178 mg/dL on 12/19/22 at 7:32 p.m.

Resident #11's medication administration record indicated a reading of 215 at 12:20 p.m. on 12/20/22. However, resident #11's CVSHealth True Metrix glucometer indicated a reading of 317 at 10:24 a.m. on 12/20/22.

REPEAT VIOLATION 9/23/22; 7/7/2022; 3/23/2022, et. al.

Plan of Correction

Accept () 01/30/2023

12/22/2022 Resident #5 had LibreFreeStyle glucometer in room per request. was taking own evening blood sugar but not reporting the readings to the staff. LPN spoke to resident and explained that we were going to need to keep the glucometer in the cart and could ring dependent if wanted reading taken in the evening. A PRN order is in place for her readings.

12/22/2022 LPN instructed the med techs on the new procedure for Resident #5 and the importance of recording all readings accurately.

1/13/2023 LPN will check during her weekly cart audits that all glucometers are stored in the cart and that all readings are being documented on the MAR. Glucometers will be checked 1X monthly.

1/26/2023 All Med techs and nurses were re-educated on the homes policy and procedure for medication administration. DON will be responsible for monitoring med techs and nurses for compliance weekly. Weekly med cart audits will continue. A copy of the documented training will be submitted after POC is accepted.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented - 04/14/2023

187a - Medication Record**20. Requirements**

2600.

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

Description of Violation

Resident #1's medication administration record for December 2022 did not indicate the diagnosis or purpose of the resident's Humalog Kwikpen 100 UNIT/ML, inject 10 units subcutaneously three time daily before meals.

Resident #1's medication administration record for December 2022 did not indicate the diagnosis or purpose of the resident's Levemir FlexTouch 100 UNIT/ML, inject 35 units subcutaneously at bed time.

Resident #4's medication administration record for December 2022 did not indicate the diagnosis or purpose of the

187a - Medication Record (continued)

resident's Insulin Lisp Inj Pro 75/25 Pen, inject per sliding scale with breakfast and dinner; if <80=0U; 81 99=16U; 100 119=20U; 120 150=24U; 151 200=28U; >200 = 32U.

Resident #11's medication administration record for December 2022 did not indicate the diagnosis or purpose of the resident's Novolog Flexpen 100 UNIT/ML, inject 10 units subcutaneously three times daily before meals.

Resident #11's medication administration record for December 2022 did not indicate the diagnosis or purpose of the resident's Basaglar Inj 100 UNIT, inject 20 units subcutaneously once daily in the mornings.

Resident #14's medication administration record for December 2022 did not indicate the diagnosis or purpose of the resident's Tradjenta Tab 5mg, take one tablet by mouth once daily.

REPEAT VIOLATION 9/23/22; 7/7/2022; 3/23/2022, et. al.

Plan of Correction

Directed [REDACTED] 01/30/2023)

12/21/2022 This is an issue with our pharmacy. When a new refill is processed the pharmacy is not carrying over the DX. We have made them aware of this ongoing issue.

12/21/2022 Nursing is reviewing the new orders to check for DX carry over. Correcting the EMAR when found. We are also working with the software company that we use for our EMAR for a way to "map/merge" the DX from the original order.

1/13/2023 Nursing is responsible for reviewing the EMAR and will continue to correct the DX issue until it can be resolved with the Pharmacy.

1/27/2023. Monitoring for DX on the MAR will be included during the weekly med cart audit . LPN / DON will be responsible for correcting any DX that was not included by the pharmacy during medication entry on the MAR .

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall confirm that the medication administration records for the residents cited in this violation have been corrected. 1/30/23 [REDACTED]

Directed Completion Date: 01/31/2023

Not Implemented [REDACTED] 04/14/2023)

191 - Resident Right to Refuse**21. Requirements**

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

There is no documentation that resident #6 has been educated on the right to question or refuse a medication if the resident believes there may be a medication error.

191 - Resident Right to Refuse (*continued*)**Plan of Correction****Accept** [REDACTED] - 01/30/2023)

1/3/2023 - Executive Director met with resident #6 during the corrected contract signing. Resident Rights was reviewed at that time with resident. . Right to refuse and/or question medication was explained. Resident acknowledged the resident rights review.

1/3/2023 A complete residency agreement was signed by resident #6 and a signed copy of her acknowledgement is in [REDACTED] resident record.

1/27/2023 Executive Director will be present at all lease signing for new residents. Resident rights will be reviewed with each new resident during that time. A copy of the Resident Rights that include the right to refuse medication is included in the resident contract between home and the resident. All current resident files have been reviewed by the Executive Director to ensure each resident has a resident contract in their file.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented [REDACTED] - 04/14/2023)

224a - Preadmission Screen Form

22. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

The preadmission screening form for resident #12, dated 2/18/22, did not indicate that the home can meet the resident's needs.

Plan of Correction**Accept** [REDACTED] - 01/23/2023)

12/22/2022- Executive Director reviewed resident #12's resident record from date of admission. Executive Director felt confident that resident's needs could be met prior to admission on 2/18/2022. Executive Director checked the box that acknowledges that her needs could be met.

1/3/2023 - Executive Director reviewed pre-screening forms for all current residents and checked that all appropriate boxes were completed.

1/13/2023 - Executive Director or Director of Nursing will complete all pre-screening forms for new residents. Executive Director will review all forms at time of lease signing to ensure they are complete.

Licensee's Proposed Overall Completion Date: 01/13/2023

Not Implemented [REDACTED] - 04/14/2023)

225a - Assessment 15 Days

23. 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.

225a - Assessment 15 Days (continued)

Description of Violation

Resident #6 was admitted to the home on [REDACTED]. However, resident #6's initial assessment is dated 11/27/21.

REPEAT VIOLATION 3/23/2022, et. al.; 5/12/21 et. al.

Plan of Correction

Accept [REDACTED] - 01/30/2023)

12/22/2022- Resident #6 was admitted into [REDACTED]. Prior administrator did not complete the initial assessment in a timely manner.

11/22/22 - Resident #6 did have a new RASP completed. RASP was reviewed with resident at that time and resident acknowledged the assessment.

1/13/23 - Director of Nursing or Executive Director will be responsible for completing initial assessment for all new residents. They will ensure all assessments are completed within 15 days of admission and reviewed with the resident prior to signing.

1/27/2023 All current resident records have been reviewed by the Executive Director. All residents have a completed assessment in their file. Executive Director will be responsible for monitoring all residents files for compliance at time of admission.

Licensee's Proposed Overall Completion Date: 01/29/2023

Not Implemented [REDACTED] - 04/14/2023)

227a - Support Plan 30 Days

24. Requirements

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 #6 was admitted to the home on [REDACTED]. However, resident #6's initial support plan is dated 11/27/21.

Plan of Correction

Accept [REDACTED] - 01/30/2023)

12/22/2022- Resident #6 was admitted into [REDACTED]. Prior administrator did not complete the support plan in a timely manner.

11/22/22 - Resident #6 did have a new support plan completed. RASP was reviewed with resident at that time and resident acknowledged the support plan.

1/13/23 - Director of Nursing or Executive Director will be responsible for completing initial support plan for all new residents. They will ensure all assessments are completed within 15 days of admission and reviewed with the resident prior to signing.

1/27/2023 All current resident records have been reviewed by the Executive Director. All residents have a completed support plan in their file. Executive Director will be responsible for monitoring all residents files for compliance at time of admission.

227a - Support Plan 30 Days (continued)**Licensee's Proposed Overall Completion Date: 01/29/2023****Not Implemented (04/14/2023)**