pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **TITHONUS MT. LEBANON LP**
LEGAL ENTITY

To operate **THE PINES OF MT. LEBANON**
NAME OF FACILITY OR AGENCY

Located at **1537 WASHINGTON ROAD, PITTSBURGH, PA 15228**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **112** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 18**

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 **August 4,** **2023** until **February 4,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **433611**

ISSUING OFFICER

Juliet Marsala
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

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: AUGUST 4, 2023

[redacted]
Tithonus Mt. Lebanon LP
[redacted]

RE: The Pines of Mt. Lebanon
1537 Washington Road
Pittsburgh, Pennsylvania 15228
License/COC #: 433611

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on January 4, 2023, January 5, 2023, January 19, 2023, March 27, 2023, and March 28, 2023, 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), failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 433610) dated June 3, 2023 – June 3, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST 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 FIRST PROVISIONAL license is enclosed and is valid from August 4, 2023 to February 4, 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 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
187(a)	II	57	$5	$285	5 calendar days from mailing date of this letter
187(b)	II	57	$5	$285	5 calendar days from mailing date of this letter
187(d)	II	57	$5	$285	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], Workload Manager
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]

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *THE PINES OF MT. LEBANON* **License #:** *43361* **License Expiration:** *06/03/2023*

Address: *1537 WASHINGTON ROAD, PITTSBURGH, PA 15228*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *TITHONUS MT. LEBANON LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/05/1990* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *72* **Waking Staff:** *54*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *02/07/2023*

Inspection Dates and Department Representative

01/04/2023 - On-Site: [redacted]
01/05/2023 - On-Site:
01/19/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112* **Residents Served:** *62*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st Floor* **Capacity:** *18* **Residents Served:** *8*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *62*
Diagnosed with Mental Illness: *7*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *10*
Have Physical Disability: *1*

Inspections / Reviews

01/04/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/18/2023*

03/03/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/05/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/09/2023*

03/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/05/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/03/2023*

07/24/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/05/2023*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/19/22, staff persons observed smoke coming from a 2nd floor light. The fire alarm was activated, residents were evacuated to fire-safe areas and the fire department was dispatched to the home; however, this incident was not reported to the Department.

On 12/25/22 and 1/3/23, the home's sprinkler system leaked water, causing the fire alarm to be activated. The fire department responded and residents were evacuated to the fire-safe areas; however, these incidents were not reported to the Department.

In the months of December, 2022 and January, 2023, there were multiple medication errors involving numerous residents, including residents #1, #2, #4 and #5; however, these medication errors were not reported to the Department.

Plan of Correction ***Directed [redacted] - 03/13/2023)***

The fire department was called to investigate smoke coming from a wall scone, they determined there was no fire. The pulled the braker. An electriction was called to repair the wall sconce the next day. They removed the damage equipment and ordered new equipment. I will do a reportable if the fire department is called. Staff was educated on 1/4/2023.
EOO, learned during our inspection that what was thought not to be a fire, due to no smoke, was actually a reportable incident and I will report any situation within 24 hours to the State.

DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator shall report the incidents to the Department of the fire department arriving to the home on 10/19/22, 12/25/22 and 1/3/23. The administrator shall also report all medication errors to the Department which occurred in the home in December, 2022 and January, 2023, including the medication errors for residents #1, #2, #4 and #5 specified in the 2600.187d violation as part of this report. Documentation of the reported incidents shall be kept. [redacted] 3/13/23

DIRECTED: By 3/20/23: All staff persons shall be educated that all reportable incidents specified in 2600.16a shall be reported to the Department within 24 hours. Documentation of the education shall be kept. [redacted] 3/13/23

DIRECTED: Beginning on 3/20/23: The administrator/designee shall review all internal incidents daily to ensure all reportable incidents specified in 2600.16a are reported to the Department within 24 hours. [redacted] 3/13/23

Directed Completion Date: *03/20/2023*

Not Implemented [redacted] - 7/24/23

187b - Date/Time of Medication Admin.

2. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed Diclofenac 1% gel–Apply topically to affected area 2 times a day. However, resident #1's December 2022 medication administration record (MAR) does not include the initials of the staff person who administered the Diclofenac gel to resident #1 at [redacted]PM on [redacted]/22 and [redacted]/22.

Resident #1 is prescribed Eliquis 2.5 mg–Take 1 tablet by mouth 2 times a day. However, resident #1's December 2022 MAR does not include the initials of the staff person who administered the Eliquis to resident #1 at [redacted]PM on [redacted]/22 and [redacted]/22.

Resident #2 is prescribed Atorvastatin 40 mg–Take 1 tablet by mouth daily. However, resident #2's December 2022 MAR does not include the initials of the staff person who administered the Atorvastatin to resident #2 on [redacted]/22.

Resident #3 is prescribed Levothyroxine 112 mcg–Take 1 tablet by mouth daily. However, resident #3's December 2022 MAR does not include the initials of the staff person who administered the Levothyroxine to resident #3 on [redacted]/22.

REPEAT VIOLATION: 5/19/2022, et. al.

Plan of Correction ***Directed [redacted] 03/13/2023)***

Med Tecs and LPN, were spoken with an trained on how to administer medications and marking them in Quick Mar. We had a staff meeting on 3/2 and all Med Tecs and LPN's received new training. (DIRECTED: Documentation of the education shall be kept.[redacted] 3/13/23).
The root cause is staff not following procedures, we have educated our MedTecs, how are qualified to administer medications, on how to administer Medications the proper way at a meeting on 3/2/2023. We will continue to educate MedTecs on the proper procedures, and the requirements and why we held to these standards for the safety of our residents.

DIRECTED: Beginning on 3/20/23: The administrator/designee shall review the medication administration records (MAR's) of at least 5 different residents weekly for 2 months then monthly thereafter to ensure all prescribed medications are present in the home for administration, all medications are administered in accordance with prescribers' orders, and that all administered medications are initialed by staff persons as administered at the time of medication administration. Documentation of the audits shall be kept. [redacted]3/13/23

Directed Completion Date: *04/03/2023* *Not Implemented[redacted] 7/24/23*

187d - Follow Prescriber's Orders

3. Requirements

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

187d - Follow Prescriber's Orders *(continued)*

Description of Violation

On 12/1/22, resident #1 was prescribed Doxycyline 100 mg–Take 1 tablet by mouth twice a day for 7 days. However, this medication was not administered to resident #1 at [redacted] AM on [redacted]/22 and [redacted]/22, or at [redacted] PM on [redacted]/22.

Numerous medications were not administered to resident #2 on numerous dates and times, to include the following:

- *Eliquis 5 mg–Take 1 tablet by mouth 2 times a day. This medication was not administered at [redacted] AM on [redacted]/22*
- *Vitamin D3 50 mcg–Take 1 capsule by mouth daily. This medication was not administered on [redacted]/22*
- *Atorvastatin 40 mg–Take 1 tablet by mouth daily. This medication was not administered on [redacted]/22 or [redacted]/22*

Numerous medications were not administered to resident #4 on numerous dates and times, to include the following:

- *Duloxetine 60 mg–Take 1 capsule by mouth daily. This medication was not administered on [redacted]/22, [redacted]/22 through [redacted]/22, [redacted]/22 through [redacted]/22, [redacted]/23 or [redacted]/23*
- *Linzess 145 mcg–Take 1 capsule by mouth daily. This medication was not administered on [redacted]/22, [redacted]/22, or [redacted]/23 through [redacted]/23*

Numerous medications were not administered to resident #5 on numerous dates and times, to include the following:

- *Eliquis 5 mg–Take 1 tablet by mouth 2 times daily. This medication was not administered at [redacted] AM on [redacted]/22 through [redacted]/22, [redacted]/22, and [redacted]/22, or at [redacted] PM on [redacted]/22, [redacted]/22, and [redacted]/22*
- *Metoprolol 25 mg–Take 1 tablet by mouth twice daily. This medication was not administered at [redacted] PM on [redacted]/22, [redacted]/22 or [redacted]/22*
- *Ventolin HFR 108 mcg–Take 2 puffs by mouth 4 times daily. This medication was not administered at [redacted] PM on [redacted]/22, at [redacted] PM [redacted]/22 or [redacted]/22, or at [redacted] PM on [redacted]/22, [redacted]/22, [redacted]/22 or [redacted]/22*

Staff person A, [redacted] and staff person B, [redacted] reported these medications were not administered to residents because staff members could not locate the medications in the medication cart.

REPEAT VIOLATION: 5/19/2022, et. al; 2/23/2022, et. al.

Plan of Correction ***Directed [redacted] - 03/13/2023)***

Med Tecs and LPN, were spoken with an trained on how to administer medications and marking them in Quick Mar. We had a staff meeting on 3/2 and all Med Tecs and LPN's received new training. (DIRECTED: Documentation of the education shall be kept. [redacted] 3/13/23).
The root cause is staff not following procedures, we have educated our MedTecs, how are qualified to administer medications, on how to administer Medications the proper way at a meeting on 3/2/2023. We will continue to educate MedTecs on the proper procedures, and the requirements and why we held to these standards for the safety of our residents. Our Medication Carts are organized, we had recently started a new procedure and there was delay in finding medications in the cart, all medications were located the day of inspection. We have our Med Tecs printing and signing the MAR after each shift.

DIRECTED: By 3/20/23: The administrator shall review all medications for residents #1, #2, #4 and #5 to ensure all prescribed medications are present and available in the home for administration. [redacted] 3/13/23

DIRECTED: Beginning on 3/20/23: The administrator/designee shall review the medication administration records (MAR's) of at least 5 different residents weekly for 2 months then monthly thereafter to ensure all prescribed medications are present in the home for administration, all medications are administered in accordance with

187d - Follow Prescriber's Orders (continued)

prescribers' orders, and that all administered medications are initialed by staff persons as administered at the time of medication administration. Documentation of the audits shall be kept. [redacted] *3/13/23*

Directed Completion Date: *04/03/2023*

Not Implemented [redacted] *- 7/24/23*

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *THE PINES OF MT. LEBANON* **License #:** *43361* **License Expiration:** *06/03/2024*

Address: *1537 WASHINGTON ROAD, PITTSBURGH, PA 15228*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *TITHONUS MT. LEBANON LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/05/1990* **Issued By:** *Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *80* **Waking Staff:** *60*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *03/28/2023*

Inspection Dates and Department Representative

03/27/2023 - On-Site: [redacted]

03/28/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112* **Residents Served:** *57*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Life Stories* **Capacity:** *18* **Residents Served:** *7*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *57*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *23*

Have Physical Disability: *3*

Inspections / Reviews

03/27/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/23/2023*

05/17/2023 - POC Submission

Submitted By [redacted] **Date Submitted:** *07/20/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/22/2023*

06/06/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/20/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/16/2023*

07/24/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/20/2023*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

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 3/27/23, at 10:17 a.m., the resident privacy coding document containing the names of multiple residents, including resident #1, resident #2, and resident #3, was attached to the license inspection summary, dated 3/4/20, and was posted on a board in the entry hall.

Plan of Correction ***Accept [redacted] 06/06/2023)***

Education on code 2600.17, confidently of resident's information was conducted on March 28, 2023. The the residents' privacy coding documents were removed from the License Inspection Book on March 27, 2023 during the Inspection [redacted] Administrator, will monitor the public areas daily, by walking the building, to ensure no confidential information is displayed in public areas.

Licensee's Proposed Overall Completion Date: *05/23/2023* *Not Implemented [redacted] - 7/24/23*

25a - Written Contract and Review

3. 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

Resident #4 was admitted to the home on [redacted]22; however, a resident-home contract was not completed.

Resident #5 was admitted to the home on [redacted]22; however, a resident-home contract was not completed until [redacted]22.

Plan of Correction ***Directed [redacted] 06/06/2023)***

Education on code 2600.25.a, the resident admission process and resident-home contract completion; including signatures and dates was conducted with Community Relations Director, on .... March 28. [redacted] Administration will review each Agreement upon admission to the community. All current resident Agreements will be audited by [redacted] by May 31, 2023, to ensure all Agreements are completed in full including signatures and dates.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall complete a written resident-home contract between the resident and the home for residents #4 and #5. 6/6/23 [redacted]

Directed Completion Date: *06/07/2023* *Not Implemented [redacted] - 7/24/23*

44g - Telephone Number

4. Requirements

2600.

44g - Telephone Number *(continued)*

44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone number of the Department's personal care home regional office was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept[redacted] - 06/06/2023)***

Education on code 2600.44.g telephone number of Personal Care home regional office, ombudsman & protective serves, being posted in conspicuous and public place in the home was conducted March 29, 2023. Such information was posted on our information board on March March 29, 2023[redacted] Administrator will monitor our information board daily to ensure information is in public view.

Not Implemented[redacted] - 7/24/23

Licensee's Proposed Overall Completion Date: *05/23/2023*

63a - First Aid/CPR Training

5. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 2/27/23, 59 residents were present in the home; however, from approximately 2:30 p.m. to 10:30 p.m., staff person A was the only staff person in the home certified in first aid, obstructed airway techniques and CPR, and from approximately 10:30 p.m. to 2/28/23 at 6:00 a.m., no staff was present in the home certified in first aid, obstructed airway techniques and CPR.

On 3/4/23, 59 residents were present in the home; however, from approximately 2:30 p.m. to 10:30 p.m., staff person A was the only staff person in the home certified in first aid, obstructed airway techniques and CPR, and from approximately 10:30 p.m. to 3/5/23 at 6:00 a.m., no staff was present in the home certified in first aid, obstructed airway techniques and CPR.

On 3/12/23, 57 residents were present in the home; however, from approximately 2:30 p.m. to 10:30 p.m., staff person A was the only staff person in the home certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Directed[redacted] 06/06/2023)***

Code 2600.63.a, one staff person for every 50 residents will be trained in first aid and CPR on each shift. On Monday, May 22, 2023, staff is attending a CPR and First Aide class.[redacted] Resident Wellness Director will monitor our staff schedule to ensure we are meeting requirements of this code daily.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall develop and implement a schedule which includes at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times. 6/6/23[redacted]

Directed Completion Date: *06/07/2023*

Not Implemented[redacted] - 7/24/23

65e - 12 Hours Annual Training

6. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person B, hired [redacted]/21, received only 4.5 hours of annual training in training year 2022.

Plan of Correction ***Accept [redacted] - 06/06/2023)***

Code 2600.65.e all Direct Care Staff will receive 12 hours of annual training relating to their job duties, we conducted annual training in 2022 using Relias and are using Senior Living University beginning in January 2023. All employees progress is being tracked & monitored by [redacted] Team Member Development & Education Coordinator, [redacted] follows progress monthly. [redacted], Director of Nursing and [redacted] Administrator will Audit annually to ensure our staff is in compliance of this code. This audit will be conducted 11/1/2023, ensuring all staff are in compliance by year end 2023. Employee B will complete [redacted] missed annual training for 2022 by June 30, 2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented [redacted] 7/24/23

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B, hired [redacted]21, did not receive training in infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2022.

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Code 2600.65.f all staff will receive training in infection control, personal care needs, safe management tech and care for residents with mental illness/intellectual disability in our community during Orientation upon hiring. All employees progress is being tracked & monitored by [redacted] Team Member Development & Education Coordinator, she follows progress monthly. [redacted] Director of Nursing and [redacted] Administrator will monitor monthly to ensure our staff is in compliance of this code. Employee B will complete this [redacted] missed training for 2022 by June 30, 2023.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall develop and implement a training policy and procedures which includes the completion of the training topics required in Regulation 2600.65(f) annually. The administrator shall audit all direct care staff training annually to ensure compliance with Regulation 2600.65(f). 6/6/23 [redacted]

65f - Training Topics *(continued)*

Directed Completion Date: *06/30/2023*

Not Implemented [redacted] - 7/24/23

65g - Annual Training Content

8. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
5. Falls and accident prevention.

Description of Violation

Staff person B, hired [redacted]/21, did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert and falls and in accident prevention during training year 2022.

Staff person C, hired [redacted]/12, did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert and in emergency preparedness procedures and recognition and response to crises and emergency situations during training year 2022.

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Code 2600.65.g, all staff & volunteers receive training fire safety, emergency preparedness and falls/accident prevention during Orientation upon hiring. All employees progress is being tracked & monitored by [redacted] Team Member Development & Education Coordinator, [redacted] follows progress monthly. [redacted] Safety and Maintenance Engineer and [redacted] Administrator will monitor monthly to ensure our staff is in compliance of this code. Employee B & C will complete this missed training for 2022 by June 30, 2023.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall develop and implement a training policy and procedures which includes the completion of the training topics required in Regulation 2600.65(g) annually. The administrator shall audit all direct care staff training annually to ensure compliance with Regulation 2600.65(g). 6/6/23 [redacted]

Directed Completion Date: *06/30/2023*

Not Implemented [redacted] - 7/24/23

85a - Sanitary Conditions

9. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/27/23 at 11:18 a.m., the bottom of the freezer in the secure dementia care unit (SDCU) kitchen was covered with large splatters of sherbet and vanilla ice cream.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Directed [redacted] 06/06/2023)***

Education for Code 2600 85.a Sanitary conditions, [redacted] Dining Experience Director will monitor kitchen sanitary conditions in our kitchens daily, all food spilled will be cleaned daily by staff. [redacted] Adminstrator will monitor daily to ensure we are in compliance with sanitary conditions. Freezer was cleaned on 3/27/2023 at 4:30pm.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall clean the bottom of the freezer in the secure dementia care unit (SDCU) kitchen. 6/6/23 [redacted]

Directed Completion Date: *06/07/2023* *Not Implemented [redacted] - 7/24/23*

91 - Telephone Numbers

10. 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 3/27/23 at 11:18 a.m., there were no emergency telephone numbers, to include the nearest hospital and fire department, on or by the telephone in the SDCU kitchen.

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Code 2600.91 Emergency Telephone Numbers posting on each telephone will be posted and audited by [redacted] Administator monthly. The phone in SDCU did received emergency telephone numbers posted on phone on March 28, 2023.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall check all telephones with an outside line to ensure the required telephone numbers in accordance with Regulation 2600.91 are posted on or by each telephone. 6/6/23 [redacted]

Directed Completion Date: *06/07/2023* *Not Implemented [redacted] - 7/24/23*

101j7 - Lighting/Operable Lamp

11. 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 3/27/23 at 11:44 a.m., there was no operable lamp or other source of lighting that could be turned on/off at resident #1's bedside.

On 3/27/23 at approximately 11:50 a.m., there was no operable lamp or other source of lighting that could be turned on/off at resident #2's bedside.

101j7 - Lighting/Operable Lamp *(continued)*

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Code 2600.101.j all staff receives training during Orientation upon hiring including, each resident will have in their bedroom an operable lamp or lighting source at bedside. Housekeeping and Wellness staff will monitor daily and report to [redacted] Hospitality Services Supervisor [redacted] will audit resident rooms monthly. Resident #2 received an additional lamp for [redacted] bedside on 3/27/2023.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall ensure that resident #1 and resident #2 have a bedside lamp which meets the Regulatory requirements of Regulation 2600.101(j)(7). 6/6/23
[redacted]

Directed Completion Date: *06/07/2023*

Not Implemented [redacted] - 7/24/23

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

12. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

On 3/27/23 at 10:46 a.m., there was no grab bar, hand rail or assist bar in the unlocked employee bathroom in the main hallway, to the left.

Plan of Correction ***Accept [redacted] - 06/06/2023)***

Code 2600.102.d Grab/Hand/Assist Bar/Slip-Resistant Surface was discussed with [redacted] Safety & Maintenance Engineer on 3/27/2023. A grab bar was purchased installed the this bathroom. All bathrooms will be monitored by [redacted] SME daily to ensure this grab bars are attached to walls. [redacted] Administior will audit monthly.

Licensee's Proposed Overall Completion Date: *05/23/2023*

Not Implemented [redacted] - 7/24/23

103g - Storing Food

13. Requirements

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

Description of Violation

On 3/27/23 at 11:18 a.m., there were 4 bowls of uncovered bowls of sherbet in the freezer in the SDCU kitchen.

Plan of Correction ***Accept [redacted] - 06/06/2023)***

Code 2600 103.g Storing Food, all employees receive training during Orientation. [redacted] Dining Experience Director will monitor food storage conditions in our kitchens daily, all food will be closed/sealed/covered daily by staff. [redacted] Administrator will monitor daily to ensure we are in compliance with food storing code. This food was disposed of on 3/27/2023 at 11:30am.

Licensee's Proposed Overall Completion Date: *05/23/2023*

Not Implemented [redacted] - 7/24/23

103i - Outdated Food

14. Requirements

103i - Outdated Food *(continued)*

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

Description of Violation

On 3/27/23 at 11:18 a.m., there were 4 bowls of unlabeled, undated bowls of sherbet in the freezer in the SDCU kitchen.

Plan of Correction ***Accept [redacted] - 06/06/2023)***

Code 2600 103.j Outdated Food, all employees receive training during Orientation.[redacted] Dining Experience Director will monitor dates of food our kitchens daily, all food will be labeled with open date and disposable date daily by staff.[redacted] Administrator will monitor daily to ensure we are in compliance with food storing code. This food was disposed of on 3/27/2023 at 11:30am.

Licensee's Proposed Overall Completion Date: *05/23/2023* *Not Implemented [redacted] - 7/24/23*

130e - Hearing Impairment

15. Requirements

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident #5 and resident #6 are unable to hear the fire alarm system. The home does not have a signaling device, approved by a fire safety expert and tested to ensure that residents are alerted in the event of a fire.

Plan of Correction ***Accept [redacted] 06/06/2023)***

Code 2600.130.e was reviewed in [redacted] Safety & Maintenance Engineer to purchase and install a signaling device approved by fire safety expert.
Bed shakers were ordered and installed for residents #5 & 6 signaling the fire alarm is going off on May 12, 2023.
[redacted] Director of Community Relations will inform [redacted] Administrator prior to a move into our community of a hearing impaired individual so [redacted] SME can purchase and install approperate signaling device prior to move in.[redacted] Administrator will monitor daily.

Licensee's Proposed Overall Completion Date: *05/23/2023* *Not Implemented [redacted] 7/24/23*

132a - Monthly Fire Drill

16. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the months of January 2022 and December 2022.

Plan of Correction ***Accept [redacted] - 06/06/2023)***

Code 2600.13s.a Monthly Fire Drill, staff received education on Fires and Fire Drills during Orientation during hiring.
[redacted] Safety & Maintenance Engineer will conduct monthly Fire Drills and document in our fire drill binder, [redacted] Hospitality Services Supervisor will monitor the fire drill binder monthly,[redacted]
Administrator will audit binder monthly.

Licensee's Proposed Overall Completion Date: *05/23/2023* *Not Implemented [redacted] - 7/24/23*

132c - Fire Drill Records

17. 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

The fire drill record does not indicate a.m. or p.m. for the fire drill conducted on 3/14/23 at 11:20.

The fire drill record does not indicate the exact amount of time it took for evacuation time for the following drills:

- *1/31/23 at 2:20 p.m.*
- *11/22/22 at 10:30 p.m.*
- *10/3/22 at 2:20 p.m.*
- *9/27/22 at 11:26 a.m.*
- *8/17/22 at 9:50 a.m.*
- *7/31/22 at 3:35 p.m.*
- *5/26/22 at 4:09 p.m.*
- *4/14/22 at 2:15 p.m.*

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Code 2600.13 c, Monthly Fire Drill, [redacted] Safety & Maintenance Engineer was educated on Fire Drills.....by ..... on.....Fire Drills will be conducted monthly and documentation in Fire Drill Binder including date, time including seconds and staff involved in the fire drill. [redacted] Hospitality Services Supervisor will monitor the fire drill binder monthly, [redacted] Administrator will audit binder monthly.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall educate the staff person responsible for conducting fire drills on the Regulatory requirements of Regulation 2600132(c). Documentation of education shall be kept. 6/6/23 [redacted]

Directed Completion Date: *06/07/2023* *Not Implemented [redacted] - 7/24/23*

132e - Fire Drill Sleeping Hours

18. Requirements

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

Description of Violation

The last fire drill conducted during sleeping hours was on 11/22/22 at 10:30 p.m. The previous sleeping hours fire drill was conducted on 2/26/22 at 11:10 p.m.

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Code 2600.132.e Fire Drills during sleeping hours. [redacted] Safety & Maintenance Engineer was educated on Fire Drills.....by ..... on.....Fire Drills will be conducted monthly and documentation in Fire Drill Binder including date, time including seconds and staff involved in the fire drill. [redacted] Hospitality Services Supervisor will monitor the fire drill binder monthly, [redacted] Administrator will audit binder monthly.

DIRECTED

132e - Fire Drill Sleeping Hours (continued)

Within one calendar day of receipt of the accepted plan of correction: The administrator shall educate the staff person responsible for conducting fire drills on the Regulatory requirements of Regulation 2600132(e). Documentation of education shall be kept. 6/6/23

Directed Completion Date: *05/23/2023*

Not Implemented - 7/24/23

132g - Fire Drills Days/Times

19. Requirements

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

Description of Violation

The home regularly schedules 3 staff persons in the home between 10:00 p.m. and 6:30 a.m.; however, the home has not conducted a fire drill with 3 staff persons within the past year.

Plan of Correction ***Directed - 06/06/2023)***

Code 2600.132.g Fire Drills Days/Time, Safety & Maintenance Engineer was educated on Fire Drills.....by ..... on.....Fire Drills will be conducted monthly and documentation in Fire Drill Binder including date, time including seconds and staff involved in the fire drill. Hospitality Services Supervisor will monitor the fire drill binder monthly, Administrator will audit binder monthly.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall educate the staff person responsible for conducting fire drills on the Regulatory requirements of Regulation 2600132(g). Documentation of education shall be kept. 6/6/23

Directed Completion Date: *05/23/2023*

Not Implemented - 7/24/23

141b1 - Annual Medical Evaluation

20. Requirements

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

Description of Violation

Resident #2's most recent medical evaluation, dated 22, does not indicate the resident's weight, pulse rate, blood pressure, temperature, immunization history, ability to self-administer medications; health status, and cognitive functioning.

Resident #7's most recent medical evaluation, dated 22, does not indicate resident's height, weight, pulse rate, blood pressure, temperature, immunization history, ability to self-administer medications, and body positioning/movement.

Plan of Correction ***Directed - 06/06/2023)***

Education for Code 2600.141.b.1 Annual Medical Evaluation was conducted on..... with Director of Nursing, and Med Tech and LPN's. learning that each resident needs an annual medical evaluation and their records need to be completed in full, including weight, pulse rate, blood pressure, temperature, immunization history, ability to self-administer medications,health status and cognitive functioning. Team Member Development & Education Coordinator will monitor resident records monthly and Administrator will Audit

141b1 - Annual Medical Evaluation (continued)

Resident Records Monthly. Resident #2 & #7 will be evaluated by physician and have their records updated at no later than their next annual medical evaluation by October 2023.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall send resident #2's and resident #7's medical evaluation forms back to the medical professional who completed the medical evaluation to have the forms completed correctly or the administrator shall have new medical evaluations completed for the residents. 6/6/23.

Within one calendar day of receipt of the accepted plan of correction: The administrator shall have all resident medical evaluation forms audited for accuracy and completeness. The staff person completing the audit shall be educated by the administrator on the completion of the form. Documentation of education shall be kept. 6/6/23 [redacted]

Directed Completion Date: *06/07/2023* *Not Implemented* [redacted] *- 7/24/23*

183d - Prescription Current

21. 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 3/27/23, the following discontinued medications, prescribed for resident #4, were in the second floor medication cart:

- *Geri-kot, discontinued on 3/3/23*
- *Benzonatate cap 100 mg, discontinued on 2/14/23*

On 3/27/23, meclizine tab 25mg, prescribed for resident #8, was in the SDCU's medication cart; however, the medication was discontinued on 3/3/23.

Plan of Correction ***Directed*** [redacted] ***- 06/06/2023)***

Education on Code 2600.183.d was conducted on March 30, 2023, with our Med Tec's and LPN's only current prescriptions, OTC, sample and CAM for residents may be in the community. Director of Nursing, [redacted] *will audit our medication carts monthly to ensure only current dated prescriptions are in our medication carts.* [redacted] *Administrator will audit carts Monthly to stay in compliance.*

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall properly dispose of the medications cited in the violation. 6/6/23 [redacted]

Directed Completion Date: *06/07/2023* *Not Implemented* [redacted] *- 7/24/23*

184a - Resident's Meds Labeled

22. 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.

184a - Resident's Meds Labeled *(continued)*

Description of Violation

Resident #2 is prescribed eye multivitamin-Take one tablet by mouth twice daily; however, the medication label indicates-Take 1 soft gel daily in the morning with a full glass of water.

Resident #4 is prescribed acetaminophen 325mg-Give 2 tablets by mouth twice daily; however, the pharmacy label indicates-Give 2 tablets by mouth twice daily with oxycodone.

Resident #4 is prescribed Senna-give 5 ml by mouth twice daily, and give 10ml at bedtime as needed for constipation; however, the pharmacy label indicates-Give 5 ml once daily.

Plan of Correction ***Accept [redacted] - 06/06/2023)***

Education on Code 2600.184.2 was conducted on March 30, 2023, with our Med Tech's and LPN's that prescription medications shall be in original containers, labeled with pharmacy label including dosage and administration instructions. On April 5, 2023, Resident $2 & #4 prescriptions were corrected to match and are on site [redacted] will audit our medication carts monthly to ensure only current dated prescriptions are in our medication carts. [redacted] Administrator will audit carts Monthly to stay in compliance.

Licensee's Proposed Overall Completion Date: *05/23/2023* *Not Implemented [redacted] - 7/24/23*

185a - Implement Storage Procedures

23. 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

On the following dates, resident #2's blood sugar readings on [redacted] glucometer did not match the blood sugar readings documented on the resident's March 2023 medication administration record (MAR):

Date	***Time***	***Glucometer reading***	***MAR***
3/9/23	*12:30 pm*	*132*	*135*
3/13/23	*6:50 am*	*130*	*210*
3/20/23	*10:26 am*	*172*	*no reading*
3/25/23	*7:04 am*	*143*	*194*

Plan of Correction ***Accept [redacted] - 06/06/2023)***

Education on Code 2600.185.a was conducted on March 30, 2023 with our Med Tech's and LPN's on our procedures for safe storage, access, security, distribution and use of medications and medical equipment, including the proper way to read and input Glucometer readings into the MAR to match. [redacted] will audit Blood Sugar Readings weekly to ensure staff is following proper procedure, [redacted] Administrator will audit glucometer readings Monthly to stay in compliance.

Licensee's Proposed Overall Completion Date: *05/23/2023* *Not Implemented [redacted] - 7/24/23*

24. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #4 is prescribed the following medications; however, on 3/27/23, these medications were not available in the home:

- *haloperidol 0.5mg/0.25ml-Give 0.5mg by mouth every 4 hours as needed*
- *lorazepam 1mg/0.5ml-Give 1mg sublingually every 4 hours as needed*
- *morphine 20mg/1ml-Give 20mg sublingually every 2 hours as needed*

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Education on Code 2600.185.a was conducted on ..... with our Med Tech's and LPN's on our procedures for safe storage, access, security, distribution and use of medications and medical equipment, including the proper way to insure we have the correct prescriptions for our residents and how to reach out to the pharmacy or physician to receive the proper prescriptions. [redacted] will audit resident prescritions weekly to ensure staff is following proper procedure, [redacted] Administrator will audit medication carts Monthly to stay in compliance.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall order the prescribed medications for resident #4. 6/6/23 [redacted]

Directed Completion Date: *06/07/2023*

Not Implemented [redacted] - 7/24/23

187a - Medication Record

25. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.
11. Special precautions, if applicable.

Description of Violation

Resident #4 is prescribed acetaminophen 325mg-Give 2 tablets by mouth twice daily; however, the resident's March 2023 MAR indicates-Give 2 tablets by mouth twice daily with oxycodone.

REPEAT VIOLATION: 2/23/2022 et al.

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Education on Code 2600.187.a was conducted on March 30, 2023 with our Med Tech's and LPN's on our medication records kept to include each resident medications are administered the dose and special precautions, ensuring the medication prescribed is being administered. [redacted] will audit the prescriptions and medications weekly to ensure staff is following proper procedure, [redacted] Administrator will audit medication carts Monthly to stay in compliance.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall update resident #4's MAR with the correct prescription. 6/6/23 [redacted]

Directed Completion Date: *05/23/2023*

Not Implemented [redacted] - 7/24/23

187d - Follow Prescriber's Orders

26. Requirements

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

Description of Violation

Resident #2 is prescribed multiple medications, including the following, that were not administered on the morning of 3/11/23:

- *amlodipine 5mg*
- *divalproex 500mg*
- *glipizide 10mg*
- *januvia 100mg*

Resident #8 is prescribed the following medications; however, on 3/27/23 the medications were not available in the home:

- *triple antibiotic ointment-Apply topically to wound on toe; cover with tefla gauze once daily until healed.*
- *medihoney gel-Apply to wound bed, lightly pack with 2x2 and cover with border gauze; secure with rolled gauze once daily*

REPEAT VIOLATION: 5/19/2022 et al.; 2/23/2022 et al.

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Education on Code 2600.18.d was conducted on .....with our Med Tech's and LPN's that prescription medications will be administered as prescribed by provider and follow instructions on label. [redacted] will audit our medication carts and MAR monthly to ensure prescriptions labels are being followed . [redacted] Administrator will audit prescriptions Monthly to stay in compliance.

DIRECTED
Within five calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons administering medications on the home's policy and procedures for medication administration and the requirements of Regulation 2600.187(d). Documentation of education shall be kept.

Within one calendar day of receipt of the accepted plan of correction: The administrator shall start an observation of each staff person administering medications once a week for four weeks to ensure the home's policy and procedures for medication administration are being followed. Documentation of observations shall be kept. 6/6/23[redacted]

Within one calendar day of receipt of the accepted plan of correction: The administrator shall start an audit of all resident MARs once a week to ensure the home's policy and procedures for medication administration are being followed and all medications were administered as prescribed. Documentation of audits shall be kept. 6/6/23 [redacted]

Directed Completion Date: *06/11/2023* *Not Implemented [redacted] - 7/24/23*

224a - Preadmission Screen Form

27. 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

No preadmission screening was completed for the following residents:

224a - Preadmission Screen Form (continued)

- *resident #4 admitted on [redacted]22*
- *resident #8, admitted on [redacted]22*

Plan of Correction ***Directed (JK - 06/06/2023)***

Education on code 2600.2.a, the resident will within 30 days of admission have a preadmission screening completed to meet the services provided by our home was conducted with Community Relations Director, on .... March 28. [redacted]Team Member Development & Education Coordinator will monitor resident records monthly and [redacted] Administrator will audit resident records monthly to ensure we are in compliance.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall complete a prescreening for residents #4 and #8 to ensure the home can meet the needs of the residents. 6/6/23

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident records to ensure a preadmission screening has been completed and the home can meet the needs of the residents. 6/6/23[redacted]

Directed Completion Date: *06/07/2023*

Not Implemented [redacted]- 7/24/23

225a - Assessment 15 Days

28. 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 #4 was admitted on [redacted]/22; however, the resident's initial assessment was completed on [redacted]/22 and does not include the diagnoses o[redacted] difficulty walking, and eyebrow laceration as indicated on the resident's medical evaluation, dated [redacted]22.

Resident #5's initial assessment, dated [redacted]/22, does not indicate diagnoses of [redacted] as indicated on the resident's medical evaluation, dated [redacted]22.

Plan of Correction ***Directed [redacted]- 06/06/2023)***

Education on code 2600.225.a, the resident will have a written initial assessment documented within 15 days of admission, was conducted with our Director of Nursing, [redacted] on ..... to ensure all residents receive an initial assessment. [redacted] Team Member Development & Education Coordinator will monitor resident records monthly and [redacted] Administrator will audit resident records monthly to ensure we are in compliance.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall update resident #4's and #5's assessment. 6/6/23[redacted]

Within one calendar day of receipt of the accepted plan of correction: The administrator shall educate the staff person responsible for auditing assessments on completion and accuracy of the form. Documentation of education shall be kept. 6/6/23

225a - Assessment 15 Days (continued)

Within five calendar days of receipt of the accepted plan of correction: The administrator shall audit all resident assessments for accuracy and completeness. 6/6/23 JK

Directed Completion Date: *06/11/2023*

Not Implemented [redacted] - 7/24/23

231b - Medical Evaluation

29. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #8 was admitted to the SDCU on [redacted]22; however, the resident's medical evaluation, dated [redacted]/22, does not indicate the need for the resident to be served in a secured dementia care unit.

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Education on code 2600.231.b, the resident will have a medical evaluation by practitioner documented on the proper form with in 60 days prior to admission including cognative screening if needing secured dementia care unit, was conducated with [redacted] Community Relations Director & [redacted] Director of Nursing on.... Resident #8 received a screening by..... on ..... to indicate the need for a secured dementia care [redacted] Team Member Development & Education Coordinator will monitor resident records monthly and [redacted] Administrator will audit resident records monthly to ensure we are in compliance.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall conduct an initial audit of all applicable resident records to ensure compliance with Regulation 2600.231(b). 6/6/23

Directed Completion Date: *06/07/2023*

Not Implemented [redacted] 7/24/23

231c - Preadmission Screening

30. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #8 was admitted to the SDCU on [redacted]/22; however, a written cognitive preadmission screening was not completed.

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Education on code 2600.231.b, the resident will have a prescreen completed by practitioner within 72 hours prior to admission for a secured dementia care unit. was conducated with [redacted] Community Relations Director & [redacted] Director of Nursing on.... Resident #8 received a screening by..... on ..... to indicate the need for a secured dementia care unit. [redacted] Team Member Development & Education Coordinator will monitor resident records monthly and [redacted] Administrator will audit resident records monthly to ensure we are in compliance.

231c - Preadmission Screening (continued)

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall conduct an initial audit of all applicable resident records to ensure compliance with Regulation 2600.231(c). 6/6/23

Directed Completion Date: *06/07/2023* *Not Implemented [redacted] - 7/24/23*

233c - Key-Locking Devices

31. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 3/27/23 at 11:20 a.m., the directions for operating the home's locking mechanism were not posted near the door that leads from the SDCU courtyard to the main courtyard.

Plan of Correction ***Accept [redacted] - 06/06/2023)***

Education on code 2600.223.c key-locking devices, electronic systems that prevent immediate egress being used to at exits will be posted in conspicuously near the device was conducted with [redacted] Maintenance & Safety Engineer and [redacted] Housekeeping Supervisior on ....., On March 24, 2023 the code was posted in a conspicuously place on the SDCU courtyard door. [redacted] will monitor daily.

Licensee's Proposed Overall Completion Date: *05/23/2023* *Not Implemented [redacted] - 7/24/23*

253c - Records Log

32. Requirements

2600.
253.c. The home shall keep a log of resident records destroyed on or after October 24, 2005. This log must include the resident's name, record number, birth date, admission date and discharge date.

Description of Violation

Multiple resident records were destroyed in 2023, including those for resident #9 and resident #10; however, the record of the destruction of records does not include the residents' dates of birth and admission and discharge dates.

Plan of Correction ***Directed [redacted] - 06/06/2023)***

Education was conducted on code 2600.253.c to attach to all destruction records for residents the date of birth, admission date and discharge date on ..... with [redacted] Administrator. [redacted] Regional Director of Operations will audit prior to any records sent for destruction.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall provide education to the responsible staff person regarding Regulation 2600.253(c). 6/6/23 [redacted]

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit 20% of all records destroyed to ensure compliance with Regulation 2600.253(c). 6/6/23

Directed Completion Date: *06/07/2023* *Not Implemented [redacted] - 7/24/23*