pennsylvania
DEPARTMENT OF HUMAN SERVICES

June 11, 2019

Ms. Loriann Putzier
President & COO
Tithonus Clearfield LP
C/O Integracare Corporation
6600 Brooktree Court, Ste. 1000
Wexford, Pennsylvania 15090

RE: Colonial Courtyard at Clearfield
1300 Leonard Street
Clearfield, Pennsylvania 16830
Certificate #: 447330

Dear Ms. Putzier:

As a result of the Department's Bureau of Human Services Licensing annual inspection on March 19, 2019 and March 20, 2019, of the above facility, the violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2800 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Jacqueline L. Rowe
Director

Enclosure
Violation Report

Violation Report

Facility Information

Name: *COLONIAL COURTYARD AT CLEARFIELD*
Address: *1300 LEONARD STREET, CLEARFIELD, PA 16830*
County: *CLEARFIELD* Region: *WESTERN*

RECEIVED License Number: *447330*

5/29/2019

Western Region Field Office
Bureau of Human Services Licensing

Administrator

Name: *Rebecca Dale* Phone: *8147652246* Email: *LPUTZIER@INTEGRACARE.COM*

Legal Entity

Name: *TITHONUS CLEARFIELD LP*
Address: *6600 BROOKTREE COURT,SUITE 1000, PA, 15090*

Certificate(s) of Occupancy

Type: *I-1* Date: *12/28/2015* Issued By: *Lawerence Township*
Type: *I-2* Date: *12/28/2015* Issued By: *Lawerence Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *88* Waking Staff: *66*

Inspection

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

Inspection Dates and Department Representative

03/19/2019 - On-Site: Ashley Roser, Jody Garvey, Josh Hoover, Deb McConnell

03/20/2019 - On-Site: Ashley Roser, Jody Garvey, Josh Hoover, Deb McConnell

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* Residents Served: *63*

Secured Dementia Care Unit

In Home: *Yes* Area: *Special Care Unit* Capacity: *17* Residents Served: *17*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *2*
Have Mobility Need: *25*
Are 60 Years of Age or Older: *63*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

3d Post license/VR/Regs

Requirements

2800.

3.d. The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

Description of Violation

On 3/19/19, the residence's license inspection summary, dated 3/15/18 et al., was not posted in a conspicuous and public place in the residence.

Repeat Violation: 3/15/18, et al.

Plan of Correction (POC)

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

"See attached POC"

See Page 2A of 11

Legal Entity Representative

Tressia Day
Signature

Tressia Day, LPN / ED 5-29-19
Printed Name and Title Date

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

The above plan of correction is approved as of 5/30/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Community Name: Colonial Courtyard Clearfield
License Number: 447330
Date of Visit: March 19 and 20, 2019
Date of Submission: May 29, 2019

1. Violation Review:
   2800.3.d-The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

2. Violation Interpretative Statement:
   On 3/19/19, the residence's license inspection summary, dated 3/15/18 et. al, was not posted in a conspicuous and public place in the residence.

3. Review the benefit of the Regulation, per RCG:
   Permits residents, families, and visitors to learn about applicable regulations and the regulatory compliance status of the residence and the residence's plan to correct any violations found.

4. Description of the Repair of the Immediate Problem:
   5/22/19- binder was updated and placed outside a public place with access to anyone entering the building to the right of the reception area. (See attached photo of placement and binder in the hallway located outside the business offices)

5. Determine / document the Root Cause of the Violation:
   ED failed to display current license inspection summary in an area that was able to be retrieved by the public.

6. Detail Action Steps / System Developed to prevent future occurrence:
   ED will add a tickler monthly to review current license and licensing inspection summary binder to ensure it posted and accessible to all visitors/residents. ED will educate all managers on 5/22/19 to location and required documents which should be in binder, new managers will be education during department orientation of location and required documents. (See attached stand-up notes and signature sheet where managers reviewed regulation)

7. Designated position responsible and specify target date for correction.
   Executive Director on 5/21/19

Authorized Signature Jessica Day Date: 5-29-19

131f Fire extinguisher inspection

Requirements

2800.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 3/19/19, no tag was present on the fire extinguisher located in hallway E of the special care unit, so it is unable to be determined if the fire extinguisher was inspected and approved by a fire safety expert within the past year.

Plan of Correction (POC)

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

"See attached POC"

See Page 3A of 11

Legal Entity Representative

Tressia Day — Signature

Tressia Day, LPN/ED — Printed Name and Title

5-29-19 — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Community Name: Colonial Courtyard Clearfield
License Number: 447330
Date of Visit: March 19 and 20, 2019
Date of Submission: May 29, 2019

1. Violation Review:
   2800.131.f- Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

2. Violation Interpretative Statement:
   On 3/19/19, no tag was present on the fire extinguisher located in hallway E of the special care unit, so it is unable to be determined if the fire extinguisher was inspected and approved by a fire safety expert within the past year.

3. Review the benefit of the Regulation, per RCG:
   Easily accessible fire extinguishers offer staff and residents the change to extinguish a fire before it spreads. Approval of fire extinguishers ensures that the devices will function properly in the event of a fire. Inspection of fire extinguishers ensures that they will function in the event of a real fire.

4. Description of the Repair of the Immediate Problem:
   On 3/25/19, a new tag was placed of fire extinguisher located in hallway of the special care unit.

5. Determine / document the Root Cause of the Violation:
   ESD did not have a plan in place to monitor tags in the special care unit when residents remove tags.

6. Detail Action Steps / System Developed to prevent future occurrence:
   On-going effective 5/21/2019 Environmental Services Director will audit all fire extinguishers monthly to ensure tags are current and in place. Documentation will be recorded in the Tels system. Education will be provided to all staff by 6/11/19 to review regulation and how to report it ESD if they find an extinguisher without a tag using a work order form. (See attached picture with tag in place on all fire extinguisher located in special care unit)

7. Designated position responsible and specify target date for correction.
   Environmental Services Director (ESD)- 5/21/19 and 6/11/19

Authorized Signature Tressia Day Date: 5-29-19

132c Fire drill records

Requirements

2800.

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 residence 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

According to staff person A, maintenance supervisor, for the fire drills conducted from 1/22/18 through 2/21/19, the only residents who evacuated to a fire-safe area, and were timed during the evacuation, were the residents who were in the affected area of the fire drill. All other residents in unaffected areas were not timed for their evacuation to fire-safe areas, so it is unable to be determined if all residents evacuated to a fire-safe area within the time specified in writing by the fire safety expert within the past year for these fire drills. However, the residence's fire drill records from 1/22/18 through 2/21/19, to include the following fire drills, indicate all residents evacuated to a fire-safe area:

** 2/21/19 at 4:05 pm: 61 residents in the residence, and 61 residents evacuated*

** 1/21/19 at 11:05 am: 58 residents in the residence, and 58 residents evacuated*

** 12/14/18 at 5:25 am: 56 residents in the residence, and 56 residents evacuated*

Plan of Correction (POC)

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

" See attached POC "

See Pages 4A and 4B of 11

Legal Entity Representative

Tressia Day — Signature

Tressia Day, LPN/ED — Printed Name and Title

5-29-19 — Date

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- ☐ Not Implemented

Community Name: Colonial Courtyard Clearfield
License Number: 447330
Date of Visit: March 19 and 20, 2019
Date of Submission: May 29, 2019

1. Violation Review:
   2800.132.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 residence 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.

2. Violation Interpretative Statement:
   According to staff person A, maintenance supervisor, for fire drills conducted from 1/22/18 through 2/21/19, the only residents who evacuated to a fire-safe area, and were timed during the evacuation, were the residents who were in the affected area of the fire drill. All other residents in unaffected areas were not timed for there evacuation to fire safe areas, so it is unable to be determined if all resident evacuated to a fire-safe area within the time specified in writing by the fire safety expert within the past year for these fire drills. However, the residence's fire drill records from 1/22/18 through 2/21/19, to include the following fire drills, indicate all residents evacuated to a fire-safe area:
   - 2/21/19 at 4:05pm: 61 residents in the residence, and 61 residents evacuated
   - 1/21/19 at 11:05 am: 58 residents in the residence, and 58 residents evacuated
   - 12/14/18 at 5:25 am: 56 residents in the residence, and 56 residents evacuated

3. Review the benefit of the Regulation, per RCG:
   Unannounced drills ensure that staff and residents will be prepared to evacuate without hesitation in the event of a real fire. Evacuation within the maximum evacuation time prevents fire-related death and injury. It is critical to practice response and evacuation while residents are asleep, since an individual's response time and actions when waking from sleep are reduced, and because most fire deaths occur during sleeping hours. Varying the location of the fire and the exit routes used ensures that staff and residents are prepared to respond to different fire scenarios. Staffing drill dates and times ensures that staff and residents prepared to respond to different fire scenarios, and that staff on all shifts are properly trained in evacuation procedures. Designated meeting places and communication systems ensure that residents are accounted for during actual fires to ensure total evacuation and prevent death or injury from wandering. Elevators may be inoperative during fires, causing people to become trapped in the building.

4. Description of the Repair of the Immediate Problem:
   Unable to complete fire drills for violation 2800.132.c from 1/22/18 through 2/21/19. On 5/22/19 Environmental Services Director (ESD) was educated on current Fire Drills per regulation timing of a drill to include fire drill time begins when the alarm is sounded and ends when the last resident enters the meeting place.

Authorized Signature Teresa Day Date: 5-29-19

5. Determine / document the Root Cause of the Violation:
   ESD was not educated on the update to the regulation 2800.132.c regulatory clarifications of timing of a drill.

6. Detail Action Steps / System Developed to prevent future occurrence:
   ESD reviewed regulation clarification-January 2019 with all managers on 5/22/19. ESD will education all staff by 6/11/19 regarding the clarification of fire drills regulation 2800.132.c. ED will review all fire drills for compliance and sign off if drill was documented appropriately after each drill. A review of drill will also be complete during the Safety Meeting monthly.

7. Designated position responsible and specify target date for correction.
   ESD 5/22/19 and 6/11/19

Authorized Signature Tussie Diaz Date: 5-29-19

132d Evacuation

Requirements

2800.

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 residence.

Description of Violation

According to staff person A, maintenance supervisor, for the fire drills conducted from 1/22/18 through 2/21/19, the only residents who evacuated to a fire-safe area, and were timed during the evacuation, were the residents who were in the affected area of the fire drill. All other residents in unaffected areas were not timed for their evacuation to fire-safe areas, so it is unable to be determined if all residents evacuated to a fire-safe area within the time specified in writing by the fire safety expert within the past year for these fire drills.

Plan of Correction (POC)

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

" See attached POC "

See Pages 5A and 5B of 11

Legal Entity Representative

Tressia Day
Signature

Tressia Day, LPN/ED
Printed Name and Title

5-29-19
Date

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

Plan of correction implementation status as of 5/30/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Community Name: Colonial Courtyard Clearfield
License Number: 447330
Date of Visit: March 19 and 20, 2019
Date of Submission: May 29, 2019

1. Violation Review:
   2800.132.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 fires safety expert may not be a staff person of the residence.

2. Violation Interpretative Statement:
   According to staff person A, maintenance supervisor, for the fire drills conduction from 1/22/18 through 2/21/19, the only residents who evacuated to a fire-safe area, and were timed during the evacuation, were the residents who were in the affected area of the fire drill. All other residents in unaffected areas were not timed for their evacuation to fire safe areas, so it is unable to be determined if all resident evacuated to a fire-safe area within the time specified in writing by the fire safety expert within the past year for these fire drills.

3. Review the benefit of the Regulation, per RCG:
   Unannounced drills ensure that staff and residents will be prepared to evacuate without hesitation in the event of a real fire. Evacuation within the maximum evacuation time prevents fire-related death and injury. It is critical to practice response and evacuation while residents are asleep, since an individual's response time and actions when waking from sleep are reduced, and because most fire deaths occur during sleeping hours. Varying the location of the fire and the exit routes used ensures that staff and residents are prepared to respond to different fire scenarios. Staffing drill dates and times ensures that staff and residents prepared to respond to different fire scenarios, and that staff on all shifts are properly trained in evacuation procedures. Designated meeting places and communication systems ensure that residents are accounted for during actual fires to ensure total evacuation and prevent death or injury from wandering. Elevators may be inoperative during fires, causing people to become trapped in the building.

4. Description of the Repair of the Immediate Problem:
   Unable to complete fire drills for violation 2800.132.c from 1/22/18 through 2/21/19. On 5/22/19 Environmental Services Director (ESD) was educated on current Fire Drills per regulation timing of a drill to include fire drill time begins when the alarm is sounded and ends when the last resident enters the meeting place.

5. Determine / document the Root Cause of the Violation:
   ESD and ED was currently not aware of regulation in regard to violation 2800.132 (d) until regulatory clarification- January 2019 was disturbed to community ED.

Authorized Signature Susan Day Date: 5-29-19

6. Detail Action Steps / System Developed to prevent future occurrence:
   ESD reviewed regulation clarification-January 2019 with all managers on 5/22/19. ESD will education all staff by 6/11/19 regarding the clarification of fire drills regulation 2800.132.c. ED will review all fire drills for compliance and sign off if drill was documented appropriately after each drill. A review of drill will also be complete during the Safety Meeting monthly.

7. Designated position responsible and specify target date for correction.
   ESD on 5/22/19 and 6/11/19

Authorized Signature Jessica Day Date: 5-29-19

141b1 Annual medical evaluation

Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #1's most recent tuberculin skin test was conducted on 4/11/16.

Resident #3's most recent tuberculin skin test was conducted on 5/2/16.

Plan of Correction (POC)

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

" See attached POC "

See Page 6A of 11

Legal Entity Representative

Tressia Day
Signature

Tressia Day, LPN/ED 5-29-19
Printed Name and Title Date

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

Plan of correction implementation status as of 5/30/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Community Name: Colonial Courtyard Clearfield
License Number: 447330
Date of Visit: March 19 and 20, 2019
Date of Submission: May 29, 2019

1. Violation Review:
   2800.141.b.1- A resident shall have a medical evaluation at least annually.

2. Violation Interpretative Statement:
   Resident #1's most recent skin test was conducted on 4/11/16.
   Resident #3's most recent skin test was conducted on 5/2/16.

3. Review the benefit of the Regulation, per RCG:
   Accurate, updated medical information helps residences decide whether a resident's needs can be met at the residence, helps the residence develop accurate assessments and support plans, and ensures that residents' medical needs will be met.

4. Description of the Repair of the Immediate Problem:
   Residents #1 and #3 received there PPD on Resident #1 chest x-ray 1/22/19 and Resident #3 chest x-ray 5/17/19. On, 5/20/19 a review of all resident was completed and anyone not having an annual PPD skin test or chest x-ray will be completed by 6/15/19 (See attached documentation of chest x-ray and PPD's administered)

5. Determine / document the Root Cause of the Violation:
   ED/DRCS failed to have in place a tickler to review annual PPD's for all residents.

6. Detail Action Steps / System Developed to prevent future occurrence:
   A tickler was created to review annual PPD's for all residents. New DRCS and DCS was education on reviewing/auditing charts for annual PPD. All staff were advised of where to locate the tickler for residents annual PPD's. ED will create a tickler to monitor monthly PPD tickler for on-going monitoring. (See attached tickler for annual PPD's)

7. Designated position responsible and specify target date for correction.
   DRCS/HCC/ED and DRCS by 1/22/19 and 5/17/19 and 6/15/19

Authorized Signature Tricia Day Date: 5-29-19

183d Current medications

Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

Resident #5 is prescribed Humalog 100/ml-Refer to sliding scale for coverage before meals twice a day. On 3/20/19, the resident's Humalog pen was dated as opened on 2/6/19; however, according to the manufacturer's instructions, the insulin pen expires 28 days after opening.

Plan of Correction (POC)

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

"See attached POC"

See Page 7A of 11

Legal Entity Representative

Tressia Day — Signature

Tressia Day, LPN/ED — Printed Name and Title

5-29-19 — Date

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- ☐ Not Implemented

Community Name: Colonial Courtyard Clearfield
License Number: 447330
Date of Visit: March 19 and 20, 2019
Date of Submission: May 29, 2019

1. Violation Review:
   2800.183.d- Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

2. Violation Interpretative Statement:
   Resident #5 is prescribed Humalog 100ml/-Refer to sliding scale for coverage before meals twice a day. On 3/20/29, the resident's Humalog pen was dated as opened on 2/6/19; however, according to the manufacturer's instructions, the insulin pen expires 28 days after opening.

3. Review the benefit of the Regulation, per RCG:
   Ensures the residence does not keep medications that are for residents no longer living in the residence or that have been discontinued.

4. Description of the Repair of the Immediate Problem:
   On 3/20/19 resident #5's Humalog 100ml was destroyed and a new bottle was replaced with the date opened while DHS was observing. (See attached destruction log we expired bottle was destroyed)

5. Determine / document the Root Cause of the Violation:
   DCS failed to complete a through audit of med cart and dispose of expired medications.

6. Detail Action Steps / System Developed to prevent future occurrence:
   Director of Resident Care Services (DRCS) will complete an education with all Med Techs and LPN's regarding expiration dates on packaging of limited use date items by 6/11/19. Direct Care Staff (DCS) will document on bottle/package when item needs to be removed from the cart in addition to date new bottle was opened. DRCS will audit med carts monthly for compliance.

7. Designated position responsible and specify target date for correction.
   MA and DRCS- 3/20/19 and 6/11/19

Authorized Signature Jessica Day Date: 5-29-19

187c Refusal to take medication

Requirements

2800.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

According to resident #3's March 2019 medication administration record (MAR), the resident refused multiple medications on multiple dates/times, to include the following, however, the medication refusals were not reported to the resident's physician:

* *Levothyroxine 100 MCG-3/4/19 at 4:54 p.m.*
* *Quetiapine Fumarate 25 MG-3/7/19 at 1:26 p.m.*
* *Memantine HCL ER 28 MG-3/7/19 at 1:26 p.m.*
* *Montelukast Sod 10 MG-3/9/19 at 4:53 p.m.*
* *Levothyroxine 100 MCG-3/9/19 at 4:53 p.m.*
* *Quetiapine Fumarate 25 MG-3/19/19 at 2:10 p.m.*
* *Memantine HCL ER 28 MG-3/19/19 at 2:10 p.m.*
* *Levothyroxine 100 MCG-3/19/19 at 4:45 p.m.*

According to resident #5's March 2019 MAR, the resident refused his Humalog 100/ml-Twice a day per sliding scale on multiple dates/times, to include the following, however, the medication refusals were not reported to the resident's physician:

* *3/5/2019 at 4:22 p.m.*
* *3/6/2019 at 4:23 p.m.*
* *3/8/2019 at 4:31p.m.*

According to resident #6's March 2019 MAR, the resident refused multiple medications on multiple dates/times, to include the following, however, the medication refusals were not reported to the resident's physician:

* *Eliquis 5 MG-3/1/19 at 8:17 p.m.*
* *Metoprolol Tartrate 25 MG-3/1/19 at 8:17 p.m.*
* *Atorvastatin 25 MG-3/1/19 at 8:17 p.m.*
* *Eliquis 5 MG-3/6/19 at 8:45 a.m.*
* *Furosemide 20 MG-3/6/19 at 8:45 a.m.*
* *Metoprolol Tartrate 25 MG-3/6/19 at 8:45 a.m.*
* *Levothyroxine 75 MCG-3/6/19 at 8:45 a.m.*

187c Refusal to take medication *(continued)*

Plan of Correction (POC)

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

"See attached POC"

See Pages 9A and 9B of 11

Legal Entity Representative

Tressia Day — Signature

Tressia Day, LPN/ED — Printed Name and Title

5-29-19 — Date

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

Plan of correction implementation status as of 5/30/19 (Date)

- ☐ Fully Implemented
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- ☐ Not Implemented

PLAN OF CORRECTION TEMPLATE

Community Name: Colonial Courtyard Clearfield
License Number: 447330
Date of Visit: March 19 and 20, 2019
Date of Submission: May 29, 2019

1. Violation Review:
   2800.187.c.- If a resident refuse to take a prescribed medication, the refusal shall be documented in the resident's record and on the mediation record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

2. Violation Interpretative Statement:
   According to resident #3's March 2019 medication administration record (MAR), the resident refused multiple medications on multiple dates/times, to include the following, however, the medication refusals were not reported to the resident's physician:
   * Levothyroxine 100 MCG-3/4/19 at 4:54 p.m.
   * Quetiapine Fumarate 25 MG-3/7/19 at 1:26 p.m.
   * Memantine HCL ER 28 MG-3/7/19 at 1:26 p.m.
   * Montelukast Sod 10 MG-3/9/19 at 4:53 p.m.
   * Levothyroxine 100 MCG-3/9/19 at 4:53 p.m.
   * Quetiapine Fumarate 25 MG-3/19/19 at 2:10 p.m.
   * Memantine HCL ER 28 MG-3/19/19 at 2:10 p.m.
   * Levothyroxine 100 MCG-3/19/19 at 4:45 p.m.

   According to resident #5's March 2019 MAR, the resident refused his Humalog 100/ml-Twice a day per sliding scale on
   multiple dates/times, to include the following, however, the medication refusals were not reported to the resident's
   physician:
   * 3/5/2019 at 4:22 p.m.
   * 3/6/2019 at 4:23 p.m.
   * 3/8/2019 at 4:31p.m.

   According to resident #6's March 2019 MAR, the resident refused multiple medications on multiple dates/times, to
   include the following, however, the medication refusals were not reported to the resident's physician:
   * Eliquis 5 MG-3/1/19 at 8:17 p.m.
   * Metoprolol Tartrate 25 MG-3/1/19 at 8:17 p.m.
   * Atorvastatin 25 MG-3/1/19 at 8:17 p.m.
   * Eliquis 5 MG-3/6/19 at 8:45 a.m.
   * Furosemide 20 MG-3/6/19 at 8:45 a.m.
   * Metoprolol Tartrate 25 MG-3/6/19 at 8:45 a.m.
   * Levothyroxine 75 MCG-3/6/19 at 8:45 a.m.

3. Review the benefit of the Regulation, per RCG:
   The residence's staff person will be able to track all medications a resident receives and to ensure all medications are administered as prescribed.

Authorized Signature _____ Date: 5-29-19

See Page 9B of 11

4. Description of the Repair of the Immediate Problem:
   Executive Director (ED) received a standing order from Medical Director (Dr. Smeal) on 3/21/19 that on Thursdays Dr. Smeal will sign off on all refusals from the previous week. All other PCP will be notified immediately of a refusal via fax transmission. (attached signed fax confirmation from Dr. Smeal, Medical Director)

5. Determine / document the Root Cause of the Violation:
   DCS was not educated of regulation 2800.187.c that PCP needs faxed for all refusals.

6. Detail Action Steps / System Developed to prevent future occurrence:
   Going forward DRCS will review daily any refusals to assure all PCP have been faxed DCS will leave a copy of refusal form in DRCS's mailbox once completed, all DCS staff will be educated by 6/11/19 in regard to faxing PCP for refusals. New hire will be educated during department orientation.

7. Designated position responsible and specify target date for correction.
   Executive Director on 3/21/19
   DRCS by 6/11/19

Authorized Signature Tressia Day Date: 5-29-19

187d Follow prescriber's orders

Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is prescribed Triphexypghenidyl 2mg/5ml Elx-Take 2ml by mouth three times daily; however, the medication was not administered from 3/1/19-3/11/19, because it was not available in the residence.

Resident #4 is prescribed Boost Very Vanilla-Drink one by mouth three times daily; however, on 3/20/19, the Boost Very Vanilla was not available in the residence.

Plan of Correction (POC)

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

"See attached POC"

See Page 10A of 11

Legal Entity Representative

Tressia Day — Signature

Tressia Day, LPN/ED — Printed Name and Title

5-29-19 — Date

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

The above plan of correction is approved as of 5/30/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Community Name: Colonial Courtyard Clearfield
License Number: 447330
Date of Visit: March 19 and 20, 2019
Date of Submission: May 29, 2019

1. Violation Review:
   2800.187.d- The home shall follow the directions of the prescriber.

2. Violation Interpretative Statement:
   Resident #1 is prescribed Triphexypghenidyl 2mg/5ml Elx-Take 2ml by mouth three times daily; however, the medication was not administered from 3/1/19-3/11/19, because it was not available in the residence. Resident #4 is prescribed Boost Very Vanilla-Drink one by mouth three times daily; however, on 3/20/19, the Boost Very Vanilla was not available in the residence.

3. Review the benefit of the Regulation, per RCG:
   Ensures that residents received medications and treatments as ordered by a physician.

4. Description of the Repair of the Immediate Problem:
   On, 3/9/19 Resident #1 medication was delivered to the community and on, 2/25/19 Resident #2's boost was delivered to the community. (See attached delivery sheets for both Triphexypghenidyl and Boost)

5. Determine / document the Root Cause of the Violation:
   DCS failed to follow up with refill and have medication on hand per physicians' orders.

6. Detail Action Steps / System Developed to prevent future occurrence:
   By 6/11/19, DRCS will education all Medication Assistants and LPN on the procedures of ordering medication and refills per policy and procedures. DRCS and LPN's will complete weekly audit of medication cart for reordering of medication.

7. Designated position responsible and specify target date for correction.
   DRCS- 6/11/19
   Pharmacy Delivery- 3/9/19 & 4/7/19 and 2/25/19 &3/20/19

Authorized Signature _____ Date: 5-29-19

225b Assessment content

Requirements

2800.

225.b. The assessment must, at a minimum include the following:

1. The resident's need for assistance with ADLs and IADLs.
2. The mobility needs of the resident.
3. The ability of the resident to self-administer medication.
4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.
5. The resident's need for supplemental health care services.
6. The resident's need for special diet or meal requirements.
7. The resident's ability to safely operate key-locking devices.

Description of Violation

Resident #2's most recent assessment, dated 12/28/18, does not include the resident's diagnosis of dementia.

Plan of Correction (POC)

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

"See attached POC"

See Page 11A of 11

Legal Entity Representative

Tressia Day — Signature

Tressia Day LPN/ED — Printed Name and Title

Date

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

The above plan of correction is approved as of 5/30/19 (Date)

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

Plan of correction implementation status as of 5/30/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Community Name: Colonial Courtyard Clearfield
License Number: 447330
Date of Visit: March 19 and 20, 2019
Date of Submission: May 29, 2019

1. Violation Review:
   2800.225.b- The assessment must, at a minimum include the following:
   - The resident's need for assistance with ADL's and IADL's.
   - The mobility needs of the resident.
   - The ability of the resident to self-administer medication.
   - The resident's medical history, medical conditions, and current medical status and how these impacts or interact with the individual's service needs.
   - The resident's need for supplemental health care services.
   - There resident's need for special diet or meal requirements.
   - The resident's ability to safely operate key-looking devices.

2. Violation Interpretative Statement:
   Residents #2's most recent assessment, dated 12/28/18, does not include the resident's diagnosis of dementia.

3. Review the benefit of the Regulation, per RCG:
   Allows residences to create a comprehensive profile of a resident's needs and serves as the basis for the plan to meet those needs.

4. Description of the Repair of the Immediate Problem:
   On 3/28/19 resident #2's assessment was updated with the current diagnosis of dementia by DRCS. (See attached ADME with updated diagnosis)

5. Determine / document the Root Cause of the Violation:
   ED and DRCS failed to review assessment upon completion to ensure all diagnosis were current and listed on assessment that were listed on the ADME.

6. Detail Action Steps / System Developed to prevent future occurrence:
   DRCS will audit all ASP's with a check list on every new admission and annual ASP's to ensure all diagnoses are listed by 6/30/19. ED will review all ASP's monthly to ensure diagnoses are not missed and sign off check with initials. DRCS will education all LPN's on 6/11/19 to update the DRCS if a new diagnosis is received.

7. Designated position responsible and specify target date for correction.
   DRCS on 6/11/19 and 6/30/19
   HCC on 3/28/19
   ED ongoing

Authorized Signature _____ Date: _____