pennsylvania
DEPARTMENT OF HUMAN SERVICES

July 1, 2019

Mr. Jeff Naden
President
Nasun, Inc.
1575 Grand Boulevard
Monessen, Pennsylvania 15062

RE: Hallsworth House
Certificate #: 428970

Dear Mr. Naden:

As a result of the Department's Bureau of Human Services Licensing annual inspection on April 12, 2019, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) 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. 2600 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: *HALLSWORTH HOUSE*
Address: *1575 GRAND BOULEVARD, MONESSEN, PA 15062*
County: *WESTMORELAND* Region: *WESTERN*
License Number: *428970*

Administrator

Name: *Jan DeForrest* Phone: *7246848170* Email: *HALLSWORTHHOUSEPA@GMAIL.COM*

Legal Entity

Name: *NASUN INC*
Address: *1575 GRAND BOULEVARD, PA, 15062*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *07/10/2000* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *71* Waking Staff: *53*

Inspection

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

Inspection Dates and Department Representative

04/12/2019 - On-Site: Ashley Roser, Desmond Grace, Jan Cutter

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *63*
Residents Served: *52*

Secured Dementia Care Unit

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

Hospice

Current Residents: *16*

Number of Residents Who:

Receive Supplemental Security Income: *1*
Diagnosed with Mental Illness: *1*
Have Mobility Need: *19*
Are 60 Years of Age or Older: *52*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

3c - Post Current License

Regulations

2600.

3.c. The personal care home 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 personal care home.

Description of Violation

The license inspection summary, dated 4/3/18, is not posted in a public and conspicuous place in the home.

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.)

Copy of the inspection summary was posted 4/12/19 on a public community bulletin board.
Administrator was educated by inspectors on site that all inspections from the annual inspection and subsequent incident inspections are to be posted, not just the most recent visit by licensing.

Administrator will ensure that all inspections including annual and subsequent visits by licensing are posted.

Legal Entity Representative

JDeforrest — Signature

J Deforrest Administrator — Printed Name and Title

5-31-19 — 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 [signature] (Initials)

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

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

15a - Resident Abuse Report

Regulations

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 3/30/19 at 9:30 p.m., staff person A received a video message on her cell phone which shows resident #4 naked in the shower, being sprayed with cold water. The video also shows resident #4 screaming out in anguish when the cold water was sprayed on her. It was later determined that staff person B was the staff person who recorded the video and sprayed the resident with cold water. However, this incident was not reported to the local Area Agency on Aging until 4/1/19 at 12:45 p.m.

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.)

1. Hallsworth House will immediately report suspected abuse to local area agency on aging.
2. Management was reeducated regarding reporting suspected abuse on 4/1/19 with emphasis on presumption of abuse.
3. Reeducated staff regarding cell phone policy, resident rights, abuse, and reporting of abuse on 4/5/19 in an emergency meeting. See attachment #2 for sign-in sheet.
4. Subsequent classes regarding cell phone policy, resident rights, abuse and reporting abuse are scheduled monthly for six months. See attachment #1 for sign-in from the second meeting and see attachment #3 for six-month schedule of meetings.

Legal Entity Representative

J DeForrest
Signature

Administrator
Jan DeForrest 5-31-19
Printed Name and Title Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

15d - Resident Abuse-Notification

Regulations

2600.

15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

On 3/30/19 at 9:30 p.m., staff person A received a video message on her cell phone which shows resident #4 naked in the shower, being sprayed with cold water. The video also shows resident #4 screaming out in anguish when the cold water was sprayed on her. It was later determined that staff person B was the staff person who recorded the video and sprayed the resident with cold water. However, this incident was not reported to the resident's designated person until 4/1/19 at 1:55 p.m.

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.)

Please see the original incident report (attachment #6) as this violation is being disputed. The identity of the resident was unknown until the staff person was interviewed at 1115am on 04/01/19. Once the identity of the individual was known, the designated person was notified at 1:55pm.

1. All incidents of suspected abuse be reported by the home to Area Agency on Aging and then the designated person or resident immediately.
2. Management was reeducated regarding reporting suspected abuse on 4/1/19 with emphasis on presumption of abuse.
3. Reeducated staff regarding cell phone policy, resident rights, and abuse on 4/5/19 in an emergency meeting. Topics included regulations regarding reporting of abuse. See attachment #2 for sign-in sheet.
4. Subsequent classes regarding cell phone policy, resident rights, abuse and reporting abuse are scheduled monthly for six months. See attachment #1 for sign-in from the second meeting and see attachment #3 for six-month schedule of meetings.

Legal Entity Representative

JDeForrest — Signature

JDeforrest Administrator 5-21-19 — Printed Name and Title / Date

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- ☐ Not Implemented

16c - Written Incident Report

Regulations

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 3/30/19 at 9:30 p.m., staff person A received a video message on her cell phone which shows resident #4 naked in the shower, being sprayed with cold water. The video also shows resident #4 screaming out in anguish when the cold water was sprayed on her. It was later determined that staff person B was the staff person who recorded the video and sprayed the resident with cold water. However, this incident was not reported to the Department until 4/1/19 at 2:48 p.m.

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.)

1. All incidents of suspected abuse will be reported by Hallsworth House to ARL within 24 hours.
2. Management was reeducated regarding reporting suspected abuse on 4/1/19 with emphasis on presumption of abuse.
3. Reeducated staff regarding cell phone policy, resident rights, and abuse on 4/5/19 in an emergency meeting. See attachment #2 for sign-in sheet.
4. Subsequent classes regarding cell phone policy, resident rights, abuse and reporting abuse are scheduled monthly for six months. See attachment #1 for sign-in from the second meeting and see attachment #3 for six-month schedule of meetings.

Legal Entity Representative

J DeForrest — Signature

Jan DeForrest - Administrator — Printed Name and Title

5-31-19 — Date

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- ☐ Not Implemented

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. The carbon monoxide detector in the main laundry room was located approximately 7'-8' from the gas dryer.

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.)

The carbon Monoxide Alarm was relocated to meet regulatory compliance. See attachment #7.

Immediately: A designated staff person shall service and inspect all carbon monoxide detectors in accordance with the manufacturer's instructions. LM 5/30/19

Legal Entity Representative

J DeForrest — Signature

Jan Deforrest Administrator — Printed Name and Title

5-21-19 — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

42b - Abuse

Regulations

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 3/30/19 at 9:30 p.m., staff person A received a video message on her cell phone which shows resident #4 naked in the shower, being sprayed with cold water. The video also shows resident #4 screaming out in anguish when the cold water was sprayed on her. It was later determined that staff person B was the staff person who recorded the video and sprayed the resident with cold water.

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.)

Upon knowledge of the accusation on 04/30/19, the team member in question was dismissed from duties immediately and removed from the schedule until the incident could be investigated. Once the allegations were founded on 4/1/19, the team member was terminated.

It is with conviction that we acknowledge, demonstrate, and enforce that all residents of Hallsworth House Personal Care Home be treated with dignity and respect. Mistreatment of residents never has, is not, and never will be tolerated on Hallsworth House Property. Anyone accused and found mistreating any resident will be terminated immediately.

1. Management was reeducated regarding reporting suspected abuse on 4/1/19 with emphasis on presumption of abuse.
2. Reeducated staff regarding cell phone policy, resident rights, and abuse on 4/5/19 in an emergency meeting. Topics included regulations regarding reporting of abuse. See attachment #2 for sign-in sheet.
3. Subsequent classes regarding cell phone policy, resident rights, abuse and reporting abuse are scheduled monthly for six months. See attachment #1 for sign-in from the second meeting and see attachment #3 for six-month schedule of meetings.
4. Cell Phone policy strictly enforced. See attachment #4.
5. Per instruction by DHS, police were notified on 05/08/19. See attachment #20.

Legal Entity Representative

J DeForrest — Signature

Jan D Forrest - Administrator — Printed Name and Title

5-21-19 — Date

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- ☐ Not Implemented

42s - Privacy

Regulations

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 3/30/19 at 9:30 p.m., staff person A received a video message on her cell phone which shows resident #4 naked in the shower, being sprayed with cold water. The video also shows resident #4 screaming out in anguish when the cold water was sprayed on her. It was later determined that staff person B was the staff person who recorded the video and sprayed the resident with cold water.

REPEAT VIOLATION: 4/3/2018

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.)

Upon knowledge of the accusation on 04/30/19, the team member in question was dismissed from duties immediately and removed from the schedule until the incident could be investigated. Once the allegations were founded on 4/1/19, the team member was terminated.

It is with conviction that we acknowledge, demonstrate, and enforce that all residents of Hallsworth House Personal Care Home be treated with dignity and respect. Mistreatment of residents never has, is not, and never will be tolerated on Hallsworth House Property. Anyone accused and found mistreating any resident will be terminated immediately.

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2. Reeducated staff regarding cell phone policy, resident rights, and abuse on 4/5/19 in an emergency meeting. Topics included regulations regarding reporting of abuse. See attachment #2 for sign-in sheet.
3. Subsequent classes regarding cell phone policy, resident rights, abuse and reporting abuse are scheduled monthly for six months. See attachment #1 for sign-in from the second meeting and see attachment #3 for six-month schedule of meetings.
4. Cell Phone policy strictly enforced. See attachment #4.
5. Per instruction by DHS, police were notified on 05/08/19. See attachment #20.

Legal Entity Representative

J DeForrest — Signature

Van DeForrest - Administrator — Printed Name and Title

5-31-19 — 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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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

85d - Trash Receptacles

Regulations

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 11: 05 a.m., there was a large uncovered trash can in the home's main kitchen, which was approximately 1/3 full of trash.

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.)

The trash receptacle was covered immediately when identified on 04/12/19 during the inspection. Both staff members employed in dietary were reeducated regarding maintaining the lid on the trash receptacle in the kitchen. All staff were educated to maintain lid on trash receptacle in the event the dietary staff are not present. During routine walk-through inspection of the home, administrator will routinely inspect the kitchen's receptacle to ensure compliance.

Legal Entity Representative

JDeForrest — Signature

Jan DeForrest - Administrator — Printed Name and Title

5-31-19 — Date

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The above plan of correction was approved by [signature] (Initials)

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

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

88a - Surfaces

Regulations

2600.

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

Description of Violation

At 10:30 a.m., there was an approximate 5" x 2" hole in the laminate floor of the main hall common bathroom. Also, the floor is in this area was lifted approximately 1"-2", posing a tripping hazard.

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.)

The area was addressed by maintenance immediately on the date of inspection 04/12/19 to eliminate safety concern. The depression was filled with cement and leveled to c reate a smooth surface. In addition, maintenance log was initiated and is available to all staff to record any maintenance concerns. See attachments #9 and #12.

Immediately, then monthly thereafter: A designated staff person shall inspect all floors, walls, ceiling, windows, doors and all other surfaces to ensure they are clean, in good repair and free of hazards. LM 5/30/19

Legal Entity Representative

J DeForrest — Signature

Jan DeForrest - Administrator — Printed Name and Title

5-24-19 — 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 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

92 - Windows

Regulations

2600.

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

Description of Violation

Multiple, operable windows, including the window in the dining room, do not have well-secured screens.

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.)

Screens were removed seasonally to be cleaned and returned during warm weather months. New procedure implemented to remove screens once per year, clean and return within the same date. All screens were returned to the windows the same day of inspection on 4/12/19. Further, during routine walk-through of facility, administrator will now include spot checking that screens are in place and in working condition.

Legal Entity Representative

J DeForest — Signature

Jan DeForest- Administrator — Printed Name and Title

5-21-19 — Date

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The above plan of correction was approved by [signature] (Initials)

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

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

95 - Furniture and Equipment

Regulations

2600.

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

Description of Violation

At 11:10 a.m., the toilet in the 2nd stall of the common resident bathroom in the reliance hall was not operable. The toilet did not fully flush and took approximately 7 minutes for the tank to refill less than halfway full of water.

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.)

The toilet was repaired by maintenance on the date of inspection 04/12/19. In addition, maintenance log was initiated and is available to staff in facility med room to notify of any utilities not working properly. Staff were educated to cite any maintenance concerns on the log. Once addressed, maintenance will document completion of repair. See attachment #12.

Immediately, then monthly thereafter: A designated staff person shall inspect all furniture and equipment to ensure they are in good repair, clean and free of hazards. JF 5/30/19

Legal Entity Representative

Signature	Printed Name and Title	Date
J DeForrest	Jan DeForrest - Administrator	5-21-19

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 JF (Initials)

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

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

101j5 - Bedside Table/Shelf

Regulations

2600.
101.j.5. A bedside table or a shelf.

Description of Violation

Resident #1's bedside table was approximately 5' from the resident's bed and could not be reached from bedside.

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.)

Resident had placed the bedside table in an area of her preference, though she did not mind having the table in the space designated by licensing. The bedside table was placed directly near the bed as permitted. Administrator will note any regulatory requirements during routine home walkthroughs and address as noted.

Immediately, then monthly thereafter: A designated staff person shall inspect all resident bedrooms to ensure each resident has a bedside table or shelf within reach of their bed. LH 5/30/19

Legal Entity Representative

JDeForrest — Signature

Jan DeForrest - Administrator — Printed Name and Title

5-21-19 — Date

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

101j7 - Lighting/Operable Lamp

Regulations

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

Resident #1's bedside lamp was located approximately 5' from the resident's bed and could not be turned on/off from bedside.

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.)

Resident had placed the bedside lamp in an area of her preference, though she did not mind having the lamp in the space designated by licensing. The bedside lamp was placed on the bedside table next to the bed as permitted by licensing. Administrator will note any regulatory requirements during routine home walkthroughs and address as noted.

Immediately, then monthly thereafter: A designated staff person shall inspect all resident bedrooms to ensure each resident has an operable lamp or other source of lighting within reach of their bed. LM 5/30/19

Legal Entity Representative

J DeForrest
Signature

Jan DeForrest - Administrator 5-21-19
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
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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

103f - Refrigerator/Freezer Temps

Regulations

2600.

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

Description of Violation

At 10:53 a.m., the thermometer on the outside of the main kitchen freezer indicated the temperature inside the freezer was 7 degrees Fahrenheit and the thermometer inside the freezer indicated the temperature was 14 degrees Fahrenheit. At 1:16 p.m., the outside thermometer indicated the temperature inside the freezer was 2 degrees Fahrenheit and the thermometer inside the freezer indicated the temperature was 12 degrees Fahrenheit.

Plan of Correction (POC)

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

The freezer temperature was adjusted on the date of inspection 4/12/19. In addition, dietary staff will check and record the temperature daily for 30 day to ensure proper temperatures. Once 30 days is completed, the temperatures will be checked and recorded by dietary every week. See attachments #10 and #11.

Legal Entity Representative

J DeForrest — Signature

Jan DeForrest-Administrator — Printed Name and Title

5-21-19 — Date

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- ☐ Not Implemented

123b - Emergency Procedures Posted

Regulations

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

At 10:20 a.m., the homes emergency procedures manual was not posted in a public and conspicuous place in the home.

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.)

Emergency procedure manual was in the home's med room which is locked when unoccupied. On the date of inspection 4/12/19 the procedures manual was moved to a public desk in the entrance of the facility. Administrator will ensure she visualizes the manual during routine walk-through of the facility.

Legal Entity Representative

J DeForrest — Signature

Jan D Forrest - Administrator - 5-31-19 — Printed Name and Title / Date

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123c - Evacuation Diagrams

Regulations

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home's emergency exit diagrams located throughout the home do not include the french doors located across from the common bathroom in the main hallway, which are labeled as exits.

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.)

The French doors were added to the home's diagram on date of inspection 4/12/19. See attachment #5.

Within 5 days of receipt of the plan of correction: A designated staff person shall inspect all emergency diagrams on all floors to ensure accuracy, and to ensure all information required in 2600.123c is present. LM 5/30/19

Legal Entity Representative

Signature	Printed Name and Title	Date
J DeForrest	Jan DeForrest - Administrator	5-2-19

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

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

141a 1-10 Medical Evaluation Information

Regulations

2600.

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #3's most recent medical evaluation, dated 1/31/19, does not include medical professional number of the medical professional who completed the form.

Resident #4's most recent medical evaluation, dated 9/29/18, does not include medical professional number of the medical professional who completed the form. Also, the resident's mobility needs was updated to indicate minimally mobile; however, does not include the date the update was completed.

REPEAT VIOLATION: 4/3/2018

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.)

The DME for resident #3 and resident #4 were sent back to physician for revision. Further, all DME's will be sent back to physician for editing immediately if the medical professional's number is absent. All DME's will be updated in accordance with licensing's regulations by facility administrator. See attachments #18 and #19.

Within 15 days of receipt of the plan of correction: The home shall review all current resident records to ensure each resident has a medical evaluation, completed in its entirety, within 60 days prior to admission or within 30 days after admission. Documentation of the audit shall be kept. 5/30/19

Legal Entity Representative

J DeForrest — Signature

Jan D'Forrest - Administrator — Printed Name and Title

5-24-19 — Date

141a 1-10 Medical Evaluation Information *(continued)*

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The above plan of correction was approved by [signature] (Initials)

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

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- ☐ Not Implemented

184a - Labeling OTC/CAM

Regulations

2600.

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

Description of Violation

Resident #2 is prescribed Albuterol HFA 90mcg-Inhale 2 puffs orally every 4 hours as needed for wheezing / shortness of breath; however, the pharmacy label indicates Albuterol HFA 90mcg-Inhale 2 puffs every 4 to 6 hours.

Resident #3 is prescribed Lorazepam 0.5mg-Take 1 tablet by mouth daily as needed; however, the pharmacy label indicates Lorazepam 0.5mg-Take 1 tablet by mouth every 3 hours as needed.

REPEAT VIOLATION: 4/3/2018

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.)

A "direction's changed sticker" was applied to the albuterol and Ativan immediately on 4/12/19. The week of 4/15/19 the following policies and procedures were implemented:

1. Any medication changes implemented in the facilities QMAR will be approved "at the cart," And ONLY performed by the facilities Administrator or facility Director. In the event the medication change occurs at a time both individuals are away from the home, medication changes will be reviewed with certified med tech by phone and then visually approved "at the cart," on the subsequent business day.
2. ALL residents returning from the hospital must have their discharge instructions REDLINED by either Administrator or Director by the following business date. Discharge instruction REDLINING will include reviewing each line of the resident's discharge instructions to ensure a medication reconciliation is performed and that all resident's needs, or appointments outlined in the instructions have been addressed. In the event a resident is discharged while both individuals are away from the home, the discharge instructions will be reviewed line by line over the phone and the instructions will be REDLINED by the next business date. A form located in the facility med room for documentation of REDLINING. See attachment #14.
3. All medication clarification noted by certified med techs will be addressed immediately while performing the five rights. A form located in the med room is available for documentation of med clarification. Any medication requiring clarification from a pharmacy or physician will be done so immediately by notifying on call pharmacy support or physician on call pager line. See attachment #13.
4. No OTC medications will be accepted from retail locations and provided by family members to prevent safety concerns. All medications must be dispensed by the home's pharmacy provider of choice.

Legal Entity Representative

J DeForrest — Signature

Jan DeForrest - Administrator — Printed Name and Title

5-21-19 — Date

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The above plan of correction was approved by [initials] (Initials)

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

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

184b - Resident's Meds Labeled

Regulations

2600.

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

Description of Violation

Resident #3 is prescribed Aspirin EC 81mg-Take 1 tablet by mouth daily; however, the over-the-counter medication does not include the resident's name.

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.)

The medication was labelled immediately on the date of inspection 4/12/19. Implemented the following week on 4/15/19 the following changes were implemented to policies and procedures:

1. Any medication changes implemented in the facilities QMAR will be approved "at the cart," And ONLY performed by the facilities Administrator or Director. In the event the medication change occurs at a time both individuals are away from the home, medication changes will be reviewed with certified med tech by phone and then visually approved "at the cart," on the subsequent business day.
2. ALL residents returning from the hospital must have their discharge instructions REDLINED by either Administrator or Director by the following business date. Discharge instruction REDLINING will include reviewing each line of the resident's discharge instructions to ensure a medication reconciliation is performed and that all resident's needs, or appointments outlined in the instructions have been addressed. In the event a resident is discharged while both individuals are away from the home, the discharge instructions will be reviewed line by line over the phone and the instructions will be REDLINED by the next business date. A form located in the facility med room for documentation of REDLINING. See attachment # 14. 3. All medication clarification noted by certified med techs will be addressed immediately while performing the five rights. A form located in the med room is available for documentation of med clarification. Any medication requiring clarification from a pharmacy or physician will be done so immediately by notifying on call pharmacy support or physician on call pager line. See attachment #13.
4. No OTC medications will be accepted from retail locations and provided by family members to prevent safety concerns. All medications must be dispensed by the home's pharmacy provider of choice.

Legal Entity Representative

Signature	Printed Name and Title	Date
J DeForrest	Jan Deforrest-Administrator	5-21-19

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

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

185a - Implement Storage Procedures

Regulations

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #3 is prescribed Atropine 1%-Give 2 drops sublingually every hour as needed; however, the medication is not available in the home.

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.)

The medication was ordered and arrived the date of inspection 4/12/19. Implemented the following week on 4/15/19 the following changes were implemented to policies and procedures:

1. Any medication changes implemented in the facilities QMAR will be approved "at the cart," And ONLY performed by the facilities Administrator or Director. In the event the medication change occurs at a time both individuals are away from the home, medication changes will be reviewed with certified med tech by phone and then visually approved "at the cart," on the subsequent business day.
2. ALL residents returning from the hospital must have their discharge instructions REDLINED by either Administrator or Director by the following business date. Discharge instruction REDLINING will include reviewing each line of the resident's discharge instructions to ensure a medication reconciliation is performed and that all resident's needs, or appointments outlined in the instructions have been addressed. In the event a resident is discharged while both individuals are away from the home, the discharge instructions will be reviewed line by line over the phone and the instructions will be REDLINED by the next business date. A form located in the facility med room for documentation of REDLINING. See attachment #14.
3. All medication clarification noted by certified med techs will be addressed immediately while performing the five rights. A form located in the med room is available for documentation of med clarification. Any medication requiring clarification from a pharmacy or physician will be done so immediately by notifying on call pharmacy support or physician on call pager line. See attachment #13.
4. No OTC medications will be accepted from retail locations and provided by family members to prevent safety concerns. All medications must be dispensed by the home's pharmacy provider of choice.

Immediately, then monthly thereafter: A designated staff person shall inspect all medication storage areas to ensure all prescribed medications are present in the home. JM 5/30/19

Legal Entity Representative

JDeForrest — Signature

Jan DeForrest- Administrator — Printed Name and Title

5-31-19 — Date

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

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

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #2 is prescribed metoprolol ER 50mg-Take 1 tablet by mouth daily-Hold if resident's heart rate is below 60 beat per minute. On 4/4/19 at 8:00 a.m., the resident's heart rate was 59 beat per minute; however, the medication was still administered to the resident.

Resident #3 is prescribed pain relief 500mg-Take 1 or 2 pills twice daily by mouth for mild or moderate pain. However, on 4/1/19 at 8:34 a.m. the resident was administered 2 tablets, at 1:51 p.m. the resident was administered 2 tablets, and at 8:29 p.m., the resident was administered 1 tablet, which exceeds the prescribed amount.

Resident #3 is prescribed Lorazepam 0.5mg-Take 1 tablet by mouth daily as needed. However, on 4/8/19, the resident was administered the medication at 2:24 p.m. and 8:16 p.m., which exceeds the prescribed amount.

Resident #3 is prescribed "monitor and record weight before administering Lasix daily at 8:00 a.m. Report any daily weight change from 3-5 lbs., or goes above 163 lbs., call doctor." On numerous dates, to include the following, the resident's weight fluctuated more than 3 pounds; however, the physician was not notified:
4/2/19: 145 from 148 on 4/1/19, which is a decrease 3 pounds
4/4/19: 150 from 143 on 4/3/19, which is an increase of 7 pounds
4/5/19: 145 from 150 on 4/4/19, which is a decrease of 5 pounds
4/7/19: 150 from 146 on 4/6/19, which is an increase of 4 pounds

REPEAT VIOLATION: 4/3/2018

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.)

Regarding resident #2 and the medication metoprolol. On 4/15/19, the certified med tech on duty when medication was administered was reeducated regarding medication administration, the five rights, and following physician orders. Disciplinary warnings were issued to the med tech on duty. Physician of resident #2 was notified. See attachment #15

Regarding resident #3 and the medication Tylenol. On 4/15/19, the certified med tech on duty when medication was administered was reeducated regarding medication administration, the five rights, and following physician orders. Disciplinary warnings were issued to the med tech on duty. Physician of resident #3 was notified. See attachment #17.

Regarding resident #3 and the medication Ativan. On 4/15/19, the certified med tech on duty when medication was administered was reeducated regarding medication administration, the five rights, and following physician orders. Disciplinary warnings were issued to the med tech on duty and processes regarding medication clarification were put in place. Physician of resident #3 was notified. See attachment #16 and #13.

Regarding resident #3 and the daily weights. Though the physician was notified by visiting nurses and staff in the home, the home's documentation did not reflect this. The physician's requests regarding notification were clarified on the same date as inspection 4/12/19. Any instructions that require notification of a medical professional will also require documentation of the facility staff to record that they are notifying the medical disciplines as instructed.

Legal Entity Representative

Immediately, then monthly thereafter: A designated person shall review all MAR's for residents with special instructions for medication administration to ensure all medications are administered in accordance with prescribers orders. JM 5/30/19

Within 15 days of receipt of the plan of correction: All staff persons qualified to administer medications shall be reeducated by a Department-approved Train-the-trainer on proper medication administration procedures, including following special instructions and orders issued by the prescriber. Documentation of the education shall be kept. 5/30/19 JM

J DeForrest — Signature

Jan D Forrest-Administrator — Printed Name and Title

5-21-19 — Date

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

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