pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: September 30, 2019

Mr. Daniel Simmons
Treasurer
Mon-Vale Non Acute Care Services, Inc.
1163 Country Club Road
Monongahela, Pennsylvania 15063

RE: The Residence at Hilltop
210 Route 837
Monongahela, Pennsylvania 15063
Certificate #: 474881

Dear Mr. Simmons:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 13, 2019; June 21, 2019 and July 3, 2019, of the above facility, the citations specified on the enclosed violation report were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), your current license # 474880 dated October 15, 2018 to October 15, 2019 is REVOKED. Additionally, your license dated October 15, 2019 to October 15, 2020 is REVOKED. A FIRST PROVISIONAL license is being issued. This FIRST PROVISIONAL license replaces all previously issued licenses and is effective for six months from the date of issuance. The license dated October 15, 2019 to October 15, 2020 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. 1026(b)(1) and 55 Pa.Code § 20.71(a)(2) (relating to conditions for denial, nonrenewal or revocation.) Your FIRST PROVISIONAL license is enclosed.

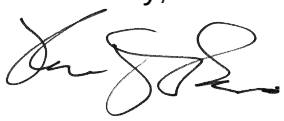
All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

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, Chs. 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:

Shivani Patel, Enforcement Manager
Human Services Licensing
Department of Human Services
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

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,



Kevin Hancock
Deputy Secretary
Office of Long-Term Living

Enclosures
License
Violation Report

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MON-VALE NON ACUTE CARE SERVICES INC**
LEGAL ENTITY

To operate **THE RESIDENCE AT HILLTOP**
NAME OF FACILITY OR AGENCY

Located at **210 ROUTE 837, MONONGAHELA, PA 15063**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE — ADDRESS OF SATELLITE SITE

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 **84**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

PROVISIONAL

Restrictions:

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

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **September 30, 2019** until **March 30, 2020**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: 474881

Robert E. Robinson
ISSUING OFFICER

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 – 7/19

RECEIVED
8/13/19
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *THE RESIDENCE AT HILLTOP* **License Number:** *474880*
Address: *210 ROUTE 837, MONONGAHELA, PA 15063*
County: *WASHINGTON* **Region:** *WESTERN*

Administrator

Name: *KIM TALIANI* **Phone:** *7242588940* **Email:** *DSIMMONS@MONVALLEYHOSPITAL.COM*

Legal Entity

Name: *MON VALE NON ACUTE CARE SERVICES INC*
Address: *1163 COUNTRY CLUB ROAD, MONONGAHELA, PA, 15063*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** **Issued By:**

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *109* **Waking Staff:** *82*

Inspection

Type: *Partial* **BHA Docket #:** **Notice:** *Unannounced*
Reason: *Complaint,Incident*

Inspection Dates and Department Representative

05/13/2019 - On-Site: Lynn Winters
05/14/2019 - Off-Site: Lynn Winters
05/15/2019 - Off-Site: Lynn Winters
05/16/2019 - Off-Site: Lynn Winters
05/17/2019 - Off-Site: Lynn Winters
05/20/2019 - Off-Site: Lynn Winters
06/20/2019 - Off-Site: Lynn Winters
07/11/2019 - Off-Site: Lynn Winters

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served:** *80*

Secured Dementia Care Unit

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

Hospice

Current Residents: *17*

Resident Demographic Data as of Inspection Dates *(continued)*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *1*
Have Mobility Need: *29*
Are 60 Years of Age or Older: *79*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

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 5/6/19, at 3:29 AM, staff person A entered resident #1's bedroom to provide incontinence care while the resident was sleeping. During this interaction, resident #1 bit staff person A's finger and staff person A struck and scratched the resident's face, which caused bruising and swelling of the left periorbital area, scattered abrasions to the left side of cheek, jaw, and neck, and bilateral subconjunctival hemorrhages. At 3:39 AM, staff person A exited the bedroom and reported to staff person B, the LPN on duty, that while providing incontinence care to resident #1, the resident had bitten his finger. Staff person B treated staff person A's injury. However, no staff checked on the resident until 7:19 AM, when a hospice worker entered his room and discovered the injuries, with blood at the head of the bed and on the right side of the pillow. The resident also coughed up bloody sputum while hospice workers provided care.

At approximately 8:15 AM, the resident was assessed by a hospice nurse who recommended to staff person C that the resident be sent to the hospital. However, the home did not call 911 for transport to the hospital until 2:29 PM. Resident #1 was admitted to the hospital in stable condition, with left suborbital swelling, a left orbital rim contusion, ecchymosis, erythema and excoriation at the left cheek, jaw, and neck, as well as bilateral subconjunctival hemorrhages.

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.)

Initial Action after the incident occurred training on abuse/neglect/residents rights was held on 5/6/2019-5/9/2019 for all direct care staff, provided by the Administrator. Exhibit 1. The policy for safe management techniques was updated by Administrator/DON/SPC (Support Plan Coordinator) based on the training that was given on 5/6-5/9/2019. A new procedure was added to include: Any resident with behaviors will have two people present to provide care and/or check on resident.(Exhibit2) Elder Abuse/Neglect/Resident Rights training will be administered twice yearly for entire building by Admin/DON/SPC. The continued training will be held every January and August of each year. 2019s training on both Safe Management techniques and Elder Abuse/Neglect/Residents Rights is scheduled for August 19,2019. The list of "two person assists" will be provided to staff monthly and as needed by SPC. Any reported incidents will be immediately assessed by the charge nurse/medtech on duty. A set of rounds will be done by a nurse/med tech every shift as well.(Exhibit 6) The staff member who was last seen with said resident resigned after his suspension.

Immediately, then at least twice per month for 3 months, and monthly thereafter: The administrator shall privately interview at least 8 residents to ensure they are not neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. Any allegations of abuse shall immediately be reported in accordance with §2600.15 and §2600.16. Documentation of interviews shall be kept.

9/5/19

42b - Abuse *(continued)*

Legal Entity Representative

Kimberly Taliani
Signature

Kimberly Taliani Administrator 8/8/19
Printed Name and Title Date

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

The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented – Adequate Progress
- ☒ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

142a - Secure Medical Care

Regulations

2600.

142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

On 5/6/19, at 3:29 AM, staff person A entered resident #1's bedroom to provide incontinence care while the resident was sleeping. During this interaction, resident #1 bit staff person A's finger and staff person A struck and scratched the resident's face, which caused bruising and swelling of the left periorbital area, scattered abrasions to the left side of cheek, jaw, and neck, and bilateral subconjunctival hemorrhages. At 3:39 AM, staff person A exited the bedroom and reported to staff person B, the LPN on duty, that while providing incontinence care to resident #1, the resident had bitten his finger. Staff person B treated staff person A's injury. However, no staff checked on the resident until 7:19 AM, when a hospice worker entered his room and discovered the injuries, with blood at the head of the bed and on the right side of the pillow. The resident also coughed up bloody sputum while hospice workers provided care.

At approximately 8:15 AM, the resident was assessed by a hospice nurse who recommended to staff person C that the resident be sent to the hospital. However, the home did not call 911 for transport to the hospital until 2:29 PM. Resident #1 was admitted to the hospital in stable condition, with left suborbital swelling, a left orbital rim contusion, ecchymosis, erythema and excoriation at the left cheek, jaw, and neck, as well as bilateral subconjunctival hemorrhages.

Plan of Correction (POC)

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Initally a meeting was held with the nurses/med techs by Administrator/DON/SPC on 5/7/2019, to discuss the importance of assessing residents immediately. (Exhibit 4) It was also in serviced that a nurse/medtech assessment on whether or not the resident needs to be sent out for further care is based on the nurse/medtech assessment not necessarily on that of the family or POAs requests. The needs of the resident are to come first.

The nurse whom was on duty the evening of this incident was written up and given further training and a copy of what is mentioned in the DHS regulations (Exhibit 5)

A revised policy was written and implemented based on the training given to nurse/medtechs on 5/7/2019 that states that a nurse/med tech will conduct their own set of rounds on all residents each shift to determine any ill, injured, or behaviors. This will be signed off in each resident's treatment sheet starting June 1,2019 (Exhibit 6) A nurse/medtech will assess any observed or reported ill, injured, or resident behaviors immediately and follow through with policy.(Exhibit 3)

Immediately, the administrator shall develop and implement policies and procedures to ensure all residents receive proper medical care in a timely manner. The policy and procedure shall include seeking the proper medical care through the resident's physician or emergency medical care. This shall include recognition and response to emergency situations and a decline in the resident's health status and the proper notification to the resident's physician and the home's administrator or the designated staff person when a resident's health status declines. SE 9/5/19

Within 30 days of receipt of the plan of correction: All staff shall be trained on these policies and procedures. Documentation of training shall be kept.

142a - Secure Medical Care *(continued)*

Legal Entity Representative

Signature | Printed Name and Title | Date

Kimberly Talarico - Administrator 8/8/2019

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

The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

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

RECEIVED
8/23/19
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: THE RESIDENCE AT HILLTOP
License Number: 47488
Address: 210 ROUTE 837, MONONGAHELA, PA 15063
County: WASHINGTON
Region: WESTERN

Administrator

Name: Kim Taliani
Phone: 7242588940
Email: ktaliani@residenceathilltop.com

Legal Entity

Name: MON VALE NON ACUTE CARE SERVICES INC
Address: 1163 COUNTRY CLUB ROAD, MONONGAHELA, PA, 15063

Certificate(s) of Occupancy

Type: C-2 LP
Date: 07/20/1998
Issued By: PA Dept L&I

Staffing Hours

Resident Support Staff: 0
Total Daily Staff: 106
Waking Staff: 80

Inspection

Type: Full
BHA Docket #:
Notice: Unannounced
Reason: Renewal

Inspection Dates and Department Representative

06/21/2019 - On-Site: Vicki Pfaff, Jan Cutter
07/03/2019 - On-Site: Vicki Pfaff, Jan Cutter

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 84
Residents Served: 83

Secured Dementia Care Unit

In Home: No
Area:
Capacity:
Residents Served:

Hospice

Current Residents: 18

Number of Residents Who:

Receive Supplemental Security Income: 0
Are 60 Years of Age or Older: 82
Diagnosed with Mental Illness: 0
Diagnosed with Intellectual Disability: 1
Have Mobility Need: 23
Have Physical Disability: 0

25c2 - Fee Schedule

Regulations

2600.

25.c. At a minimum, the contract must specify the following:

2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

Resident #1's resident-home contract, completed on 7/27/16, does not indicate the fee schedule nor indicate the actual amount of allowable resident charges.

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 Resident contact was updated in March 2018 by the Residence at Hilltop Administration. During this update the fee schedule was included

The Resident contract was updated by Residence at Hilltop Administration in March 2018 to include the fee schedule. A contract audit will be performe by the administrator or designee SE 9/5/19 to review and add an addendum. The addendum will include the fee schedule. This contract audit will be completed by August 30, 2019. See Exhibit 1&2.

Immediately: Resident #1's contract shall be updated to include a fee schedule.

SE 9/5/19

Legal Entity Representative

Kimberly Taliani — Signature

Kimberly Taliani Administrator — Printed Name and Title

8-23-19 — Date

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

Plan of correction implementation status as of 9/5/19 (Date)

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

25c12 - Bed Hold

Regulations

2600.

25.c. At a minimum, the contract must specify the following:

12. Charges to the resident for holding a bed during hospitalization or other extended absence from the home.

Description of Violation

Resident #1's resident-home contract, completed on 7/27/16, does not indicate the charges for holding a bed during extended absence from 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.)

To ensure that the entire contract is completed and there are no blank entries, a chart audit will be performed by the administrator or designee SE 9/5/19 semi-annually. The first chart audit will be completed on August 30, 2019. The semi-annual chart audit will be completed August 30th and March 30th of every year. The administrator will sign off on the audit form to ensure the audits are being performed. Exhibit 1&2

Immediately: Resident #1's resident-home contract shall be updated to include the charges for holding a bed during extended absence from the home.

SE 9/5/19

Legal Entity Representative

Signature

Kimberly Taliani Administrator 8-23-19

Printed Name and Title Date

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The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

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

65f - Training Topics

Regulations

2600.

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

Description of Violation

Direct care staff person A, hired 6/1/15, did not receive training in medication self-administration during the 2018 staff training year (1/1/18-12/31/18).

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 training topics were analyzed and broke down by who needs what type of training and when the training needs to be done by, by the Support Plan Coordinator. This was done immediately upon the completion of the inspection. A table of contents was developed to include all mandatory training along with pre-typed staff rosters sign off sheets. Exhibit 3. Each manager is now responsible for making sure their staff completed and signed off training. A final check will be performed by the Support Plan Coordinator, and given to the Administrator to ensure all staff have completed their required training. Exhibit 4 Column 3.

Immediately: Staff person A shall receive training in medication self-administration. Documentation of training shall be kept.

SE 9/5/19

Legal Entity Representative

Kimberly Talarico 8-23-19

Signature Printed Name and Title Administrator Date

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The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ 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

On 6/21/19 at 9:45 a.m., there was no thermometer in the small milk refrigerator in the home's kitchen.

Repeat Violation: 5/17/18 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.)

The thermometer was secured to the refrigerator immediately upon finding it was missing during the inspection. A picture to include that this was secured is Exhibit 5. The temperatures will be checked by staff daily and recorded on form. Exhibit 6. The Dietary Manager will check the sign off sheets weekly as well.

Any refrigerator temperatures above 40°Fahrenheit and any freezer temperatures above 0°Fahrenheit shall immediately be reported to the administrator and the refrigerator and/or freezer shall immediately be repaired or replaced.

SE 9/5/19

Within 30 days of receipt of the plan of correction: All staff persons involved in food storage and preparation shall be educated on proper food storage and safe food storage temperatures. Documentation of education shall be kept.

SE 9/5/19

Legal Entity Representative

Signature | Kimberly Talarico Administrator (Printed Name and Title) | 8-23-19 (Date)

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

The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

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

107c - Food/Water 3 Day Supply

Regulations

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 7/3/19, the home had 78 residents requiring 234 gallons to be available in the event of an emergency in order to provide 1 gal/day per resident for 3 days. The home had 132 gallons of water on site. However, the home's emergency water supply letter, dated 1/2/19, does not guarantee that the agreed upon amount of water will be delivered as a priority even in the event of a regional general emergency.

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 water emergency water supply company was contacted and a discussion on the agreement was had. At the end of the conversation it was agreed that the letter would be changed. A new letter was obtained by the dietary manager to ensure the guarantee of the water being delivered. Exhibit 7.

The 8/16/19 letter from the emergency water supply company does not indicate the agreed upon amount of water will be delivered as a priority even in the event of a regional general emergency. SE 9/5/19

Immediately: The home shall obtain and maintain at least 1 gallon of water per day per resident for 3 days or have the emergency water supply company update their letter to indicate the agreed upon amount of water will be delivered as a priority even in the event of a regional general emergency. SE 9/5/19

Immediately, then at least weekly, the administrator or designated staff person shall inventory the emergency water supply to ensure the home maintains a minimum of 3 gallons of water for each resident. Any missing inventory shall immediately be replaced.

SE 9/5/19 Documentation of inventory shall be kept for Department review. SMP 9/17/19

Legal Entity Representative

Kimberly Tallani — Kimberly Tallani, Administrator — 8-23-19

Signature — Printed Name and Title — Date

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The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

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

132c - Fire Drill Records

Regulations

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 home conducted a fire drill on 4/14/19. However, the home's fire drill record does not indicate which exits were used during this drill.

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.)

Environmental Service Director uses the Adult Residential Licensing- Personal Care Home Fire Drill 2600.132 (C). Exhibit 8. All columns and rows of information will be filled out by the Environmental Service Director after every fire drill. The administrator will audit the Fire Drill Records to ensure all information is provided semi-annually, August 30th and March 30th.

Immediately: The fire drill record for the fire drill conducted 4/4/19 shall be updated to indicate which exits were used.

SE 9/5/19

Legal Entity Representative

Kimberly Talarico Kimberly Talarico 8-23-19

Signature Printed Name and Title Date

Administrator

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

The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

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

141a - Medical Evaluation

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.

Description of Violation

The initial medical evaluation for resident #2, admitted 12/4/18, was completed on 10/3/18.
Repeat Violation: 5/17/18 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.)

A new procedure was developed to place a DME in the admission packets by the Marketing Director and returned upon admission by the family in order for the admission to be completed. A chart audit will be performed by the Support Plan Coordinator at the end of every month to ensure no DMEs are getting overlooked. Exhibit 9. The first audit will completed by August 30th.

Legal Entity Representative

Signature | Kimberly Taliani Administrator (Printed Name and Title) | 8-23-19 (Date)

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The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

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

187a - Medication Record

Regulations

2600.

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

Description of Violation

Resident #2 is prescribed Divalproex Sod DR 250mg tab – Take one tablet by mouth 2 times a day. However, the resident's July 2019 MAR indicates Divalproex sod ER 250mg – take one tablet by mouth 2 times a day for mood disorder.

[redacted] 9/5/19

[redacted] 9/5/19

Resident #3 is prescribed Morphine 20mg/ml Dose: 10mg/0.5ml Route: SL Directions: 1 syringe every 2 hours prn for pain or shortness of breath. However, the resident's July 2019 MAR indicates Morphine sulf 100mg/5ML soln – Take 1 syringe under the tongue every 2 hours as needed for pain/sob.

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.)

When an order is received: It is placed on the MAR by the person receiving the order. The nurse, the med tech, or the pharmacist will place the order on the MAR immediately after receiving the order. The order will not be approved until the medication had arrived and the order is matched to the label. The nurse or med tech who receives the medication will approve the MAR if the label matches the MAR. If the label does not match the MAR the order will be checked again and the appropriate changes will be made. If the label needs to be corrected the pharmacist will be contacted to bring up a new label and place it on the medication themselves. If the MAR needs to be corrected the nurse, med tech, or pharmacist will make the appropriate changes. Training on this new procedure and what it truly means for an Order, MAR, and Label to match was done on 6/24/2019-7/3/2019 .Exhibit 10

Legal Entity Representative

Signature

Kimberly Talarico ADMINISTRATOR 8-23-19

Printed Name and Title Date

187a - Medication Record (continued)

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

The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

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

224c - Preadmission Screening

Regulations

2600.

224.c. The preadmission screening shall be completed by the administrator or designee. If the resident is referred by a State-operated facility, a county mental health and intellectual disability program, a drug and alcohol program or an area agency on aging, a representative of the referral agent may complete the preadmission screening.

Description of Violation

Resident #4's preadmission screening, completed on 3/17/19, does not include the resident's Level of Supervision Needed, Mobility Needs and Sensory Needs. These sections were blank.

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.)

Prescreens are completed by the assessing staff member. The assessing staff member is either the Administrator, Support Plan Coordinator or the Marketing Director. The assessment will be done no more than 30 days before admission. Once a pre-screen is completed by assessing staff member a secondary staff member will check over the pre-screen. Either the administer, support plan coordinator, or marketing director whomever did not perform the assessment will do the secondary check. All three participating parties signed off an agreement to this new procedure. Exhibit 11.

Legal Entity Representative

Kimberly Taliani — Signature

Kimberly Taliani Administrator — Printed Name and Title

8-23-19 — Date

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

The above plan of correction is approved as of 9/5/19 (Date)

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

Plan of correction implementation status as of 9/5/19 (Date)

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