pennsylvania
DEPARTMENT OF HUMAN SERVICES

March 11, 2020

Ms. Mary Regina Heilman-Toth
Executive Director
Bensalem PCH, LLC
6400 Hulmeville Road
Bensalem, Pennsylvania 19020

RE: Allegria at the Oaks
License #: 143670

Dear Ms. Heilman-Toth:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 31, 2019, August 1, 2019, and November 6, 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 (relating to Personal Care Homes) 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,

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *ALLEGRIA AT THE OAKS* **License Number:** *14367*
Address: *6400 HULMEVILLE ROAD,, BENSALEM, PA 19020*
County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

Name: *Regina Heilman-Toth* **Phone:** *2157529140* **Email:** *AVI@SAGEHCP.COM*

Legal Entity

Name: *BENSALEM PCH LLC*
Address: *6400 HULMEVILLE ROAD, BENSALEM, PA, 19020*

Certificate(s) of Occupancy

Type: *I-1* **Date:** *04/21/2015* **Issued By:** *Bensalem Township*

Staffing Hours

Resident Support Staff: *165* **Total Daily Staff:** *293* **Waking Staff:** *220*

Inspection

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

Inspection Dates and Department Representative

07/31/2019 - On-Site: Sabrina Freeman, Youn Chung

08/01/2019 - On-Site: Sabrina Freeman, Youn Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *95* **Residents Served:** *76*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Grove South & North 1st floor* **Capacity:** *48* **Residents Served:** *31*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *75*
Diagnosed with Mental Illness: *8*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *52*
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

On 7/31/19, the home did not have a copy of the current license inspection summary or the 2600 regulation book for Personal Care Homes posted in a conspicuous and public 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.)

This violation was corrected immediately upon notification. (7/31/19)
Going forward, the Executive Director/Designee will monitor for compliance monthly.
Copy of the current license, license inspection summary and a copy of Chapter 2600 are located in the main living room of the building easily accessible to the public

Legal Entity Representative

Regina Heilman-Toth
Signature

REGINA HEILMAN-TOTH EXEC. DIR. 9/13/19
Printed Name and Title Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ 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

Personal care and assisted living homes must post the required influenza information in a public place in the home year-round as required by the Influenza Awareness Act (HB 1785). The home did not have an influenza poster anywhere.

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.)

This was corrected immediately upon notification. (7/31/19)
Going forward the Executive Director/Designee will monitor on a monthly basis that the Influenza poster remains posted in the lobby of the main entrance, which is accessible to the public.

Legal Entity Representative

Regina Heilman-Toth
Signature

REGINA HEILMAN-TOTH 9/13/19
Printed Name and Title EXECUTIVE DIRECTOR Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

51 - Criminal Background Check

Regulations

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The home failed to obtain criminal background checks for employees through the PA State Police Request for Criminal Record Check form (SP4-164) or via the E-Patch, specifically for staff persons A, B, and C.

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.)

Staff persons A, B, and C had repeat background checks completed using the PA e-Patch System which were completed on 8/5/19 and 8/6/19.
Going forward PA e-Patch will be used for all background checks of new hires. Director of Administrative Services/Designee will be responsible for ongoing compliance. ED/Designee to audit all new employee files monthly.

Legal Entity Representative

Regina Heilman-Foth
Signature

REGINA HEILMAN-FOTH EXECUTIVE DIRECTOR
Printed Name and Title

9/13/19
Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

82c - Locking Poisonous Materials

Regulations

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 8/1/19, a Santec Blue glass container, which says 'seek medical attention when ingested' was observed in the unlocked hair salon located in the home's secured dementia care unit on the ground floor.

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 hairdresser has been educated by the Executive Director about the importance and necessity of securing all chemicals.
A sign has been posted on the salon door as a reminder that the door must be locked at all times when not in use.
Executive Director/Designee to monitor for compliance weekly for 4 weeks

Legal Entity Representative

Regina Heilman-Toth — Regina Heilman-Toth 9/13/19 EXECUTIVE DIRECTOR

Signature | Printed Name and Title | Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

96a - First Aid Kit

Regulations

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the home's van was missing a thermometer and breathing shield.

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 thermometer and breathing shield have been added to the first aid kit on the bus by the Director of Activities.
Going forward, the Director of Activities is responsible for replacing missing items.
A tag placed on the lock will indicate if the the box has been opened for use. This will alert the Director of Activities to check for missing items that may need to be replaced

Legal Entity Representative

Regina Heilman-Toth
Signature

REGINA HEILMAN-TOTH 9/13/19
Printed Name and Title Date
EXECUTIVE DIRECTOR

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

101j2 - Bedroom Chairs

Regulations

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

Bedroom #38 is occupied by two residents; however, there was only one chair in the bedroom.

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 missing chair from room 38 was replaced immediately when reported (8/1/19)
Each manager/designee is responsible to complete room checks in a given hallway on a weekly basis utilizing checklist attached. The checklist is then submitted to the Executive Director/Maintenance Director for review.

The Director of Maintenance will verify with the Executive Director
that missing items have been replaced and/or repaired as soon as possible, but not longer than three working days.

Legal Entity Representative

Regina Heilman-Toth — REGINA HEILMAN TOTH 9/13/19

Signature — Printed Name and Title — Date

EXECUTIVE DIRECTOR

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

The above plan of correction is approved as of 03-11-2020 (Date)

Plan of correction implementation status as of 03-11-2020 (Date)

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

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ 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

The home's emergency procedures are not posted in a conspicuous and public 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.)

The Emergency Management Plan was posted in a conspicuous place (available to public) immediately during day of inspection (7/31/19)
Going forward, the Executive Director will check that the Emergency Management Plan remains in place. Audit will be completed the first week of the month each month for 6 months.

Legal Entity Representative

Signature

REGINA HEILMAN-TITH 9/13/19
Printed Name and Title Date
EXECUTIVE DIRECTOR

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (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

Resident #1 was admitted to the home on 4/16/19. As of 7/31/19, the home has not completed a medical evaluation for the resident.

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 #1 no longer resides in the community. The Director of Marketing is responsible to secure the DME prior to accepting a resident for admission.
The Director of Resident Services/Nurse will review DME on or before the day of admission. Each residents' file has been audited for compliance.
(see attached)

Legal Entity Representative

Signature | Printed Name and Title | Date

REGINA HEILMAN-KOTH 9/13/19
EXECUTIVE DIRECTOR

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

Resident #2's last medical evaluation was completed on 5/22/18. As of 7/31/19, resident #2 did not have an annual medical evaluation.

Resident #3's last medical evaluation was completed on 9/25/17. As of 7/31/19, resident#3 did not have an annual medical evaluation.

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 #2 no longer resides at the community; resident #3 had his annual medical evaluation completed on 7/25/2019
Each resident currently has an up to date medical evaluation completed and in resident file
Going forward, the attached tracking tool will be used to maintain compliance.
The Nurse/designee is responsible for continued compliance.

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN TOTH, EXECUTIVE DIRECTOR — Printed Name and Title

9/13/19 — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

182c - Medication Administration

Regulations

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On 8/1/19 at approximately 10AM, the Licensing Representative observed a cup with 3 pills (one pink and two white) on a cart next to resident #6's bed in room #30. Resident #6 stated she didn't know it was there. Staff person D, the med-tech on duty said she administered the resident's morning meds and saw the resident swallow the pills before she left. Staff person D checked the pill packs and identified the pink pill as one from the previous day's 4:00 PM medication.

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.)

Medication in cup at bedside of resident #6 removed immediately upon discovery. and disposed of accordingly.

Med techs were re-trained regarding proper med management techniques, and importance of observing each resident's medication is administered as directed. (see attached)

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH EXECUTIVE DIRECTOR — Printed Name and Title

9/13/19 — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

183d - Prescription Current

Regulations

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 08/01/2019, discontinued medication was observed in resident #3's medication bin, specifically the Spiriva Respimat.

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 #3's Spiriva was immediately removed from the med cart and discarded.
Pharmacy consultant visited on 8/16/19 and completed audit of all med carts.
Med techs re-trained by Director of Residential Services regarding removal of discontinued medications from cart promptly and bringing them to the nursing office for disposal by returning to pharmacy or manually disposing as per policy
Med Tech's are responsible to complete weekly audits of the cart for discontinued or expired medications. The audit will be overseen by the nurse. Quarterly audits are performed by the pharmacy consultant.
(see attached)

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH EXECUTIVE DIRECTOR — Printed Name and Title

9/13/19 — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ 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:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for resident #3's Morphine Sul 15mg tablet reads, take one tablet by mouth 3 times daily at 6AM, 2PM and 10PM. However, the narcotic sheet documents 9AM, 5PM and 9PM.

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.)

Nurses and med tech's were educated on comparing medication to MAR and narcotic sheet for clarification of correct order. Any changes in direction require a new label obtained from pharmacy

Resident #3's morphine clarified by MD and order corrected

All nurses and med techs educated on 3 point check that is required. (see attached)

Legal Entity Representative

Regina Heilman-Toth
Signature

REGINA HEILMAN-TOTH 9/13/19
Printed Name and Title Date
EXECUTIVE DIRECTOR

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ 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's medication bin had an open over-the-counter bottle of Melatonin. The Melatonin was not labeled with the resident's name.

Resident #7 is prescribed Cerovite; however there was an over-the-counter bottle of Centrum Silver which staff stated replaced the Cerovite. The Centrum Silver was not labeled with 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.)

Resident #3's Melatonin was labeled with his name.
Resident #7's Centrum Silver was labeled with her name.
Staff re-trained about necessity of labeling every OTC medication with resident name.
(see attached)

Legal Entity Representative

Regina Heilman-Toth
Signature

REGINA HEILMAN-TOTH 9/13/19
Printed Name and Title Date
EXECUTIVE DIRECTOR

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ 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 #1 is prescribed 500mg of MAPAP as needed for pain. On 8/1/19, the medication was not available in the home.

Resident #3 is prescribed 325mg MAPAP as needed for pain or fever. On 8/1/19, the medication was not available in the home.

Resident #3 is prescribed 800mg Ibuprofen as needed for pain. On 8/1/19, the medication was not available in the home.

Resident #3 is prescribed 400mg Magnesia as needed at bedtime. On 8/1/19, the medication was not available in the home.

Resident #3 is prescribed a Fleet Enema as needed. On 8/1/19, the medication was not available in the home.

Resident #7 is prescribed 500mg MAPAP as needed for pain. On 8/1/19, the medication was not available in the home.

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

On 3/12/19, resident #3's family dropped off 75 Percocet pills, and again on 4/18/19 the family dropped off 75 Percocet pills. On 4/18/18, resident #3 was admitted to the hospital and did not return back to the home until 5/7/19.

On 5/21/19, staff person E asked staff person F for resident #3's Percocet pills. Upon retrieval of the pills it was discovered that 40 Percocet pills were missing.

Resident #3's Percocet pills were not stored on the med-cart. The pills were kept in staff person G's office in a double locked cabinet. The home failed to follow policy & procedure regarding medication storage.

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 #1 and #7 no longer reside in community. Resident #3's Tylenol, Ibuprofen Magnesium and Fleets enema obtained from pharmacy and are available. Resident #3's Percocet transferred to narcotic cabinet of med cart. Any/all controlled substances kept in secure narc box under double lock and counted every shift. Director of Residential Services responsible for ongoing compliance.

185a - Implement Storage Procedures *(continued)*

Legal Entity Representative

Signature: Regina Heilman-Toth

Printed Name and Title: REGINA HEILMAN-TOTH EXECUTIVE DIRECTOR

Date: 9/13/19

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

The above plan of correction is approved as of 03-11-2020 (Date)

Plan of correction implementation status as of 03-11-2020 (Date)

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

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ 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:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1's medication administration record did not include the diagnosis or purpose for six medications listed on the MAR.

Resident #3 is prescribed 15mg of Morphine Sul. 15mg tablet. However, resident #3's medication administration record does not list or include the medication. In addition, there were five medications listed on the medication administration record that did not include the diagnosis or purpose for the medication.

The pharmacy label for resident #3's Ibuprofen 800mg tablet reads, take 1 tablet by mouth every 6 hours as needed. However, the medication administration record documents Ibuprofen 800mg - take 1 tablet by mouth every 8 hours as needed for pain.

Resident #7 is prescribed 300mg of Irbesartan once daily which is packaged in an individual pill pack. The medication administration record also documents Irbesartan 300mg - take 1 tablet by mouth daily. However, the pharmacy label reads, Irbesartan 150mg - take 1 tablet by mouth daily.

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 #1 and #7 no longer in community. Resident #3 Ibuprofen clarified with MD and corrected. Prescribers have been informed that each script must have the diagnosis and use of each prescibed medication. This will be documented on the MAR for each individual medication Nurses to monitor prescriptions received and transcribe to MAR as indicated Staff re-trained on 10 point check. (see attached)

187a - Medication Record *(continued)*

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH EXECUTIVE DIRECTOR — Printed Name and Title

9/13/19 — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

187b - Date/Time of Medication Admin.

Regulations

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

Description of Violation

Resident #7's, medication administration record does not include the initials of the staff person who administered:

- Dok Softgel on 7/6/19 at 8PM or 7/16/19 at 8AM
- Aspirin on 7/6/19 at 8AM
- Cerovite on 7/8/19 or 7/16/19 at 8AM
- Fish oil on 7/6/19 at 8PM or 7/16/19 at 8AM
- Biotene on 7//19 at 5PM
- Hydralazine on 7/6/19 at 5PM or 7/16/19 at 8AM or 12PM
- Escitalopram on 7/16/19 at 8AM
- Doxepin on 7//19 at 8PM
- Ranitidine on 7/6/19 at 8PM or 7/16/19 at 8AM
- Allopurinol on 7/16/19 at 8AM
- Carvedilol on 7/6/19 at 8PM or 7/16/19 at 8AM
- Amlodipine on 7/16/19 at 8AM
- Atorvastatin on 7/16/19 at 12PM
- Ibuprofen on 7/6/19 at 8PM
- Lorazepam on 7/6/19 or 7/22/19 at 8PM

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 #7 no longer resides in community.
The initials of the nurse/med tech administering medications will document the medication as "given" immediately after administration using her initials. Med Techs and nurses re-trained on task (see attached). Director of Residential Services to monitor for ongoing compliance

187b - Date/Time of Medication Admin. *(continued)*

Legal Entity Representative

Regina Heilman-Toth
~~REGINA H~~ ERROR
Signature

REGINA HEILMAN-TOTH 9/13/19
Printed Name and Title EXECUTIVE DIRECTOR
Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

Plan of correction implementation status as of 03-11-2020 (Date)

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

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ 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 #3 is prescribed 30mg of Morphine Sulfate every 8 hours for pain. This medication was not administered to resident #3 on 7/14/19 at 2PM because the medication was not available in the home. Additionally, on 8/1/19 the medication was not available in the home.

Resident #3 is prescribed .25mg of Alprazolam daily at bedtime. This medication was not administered to resident #3 on 7/7, 7/8, 7/12, 7/13, 7/24 or 7/26/19 because the medication was not available in the home.

Resident #3 is prescribed Breo Ellipta every 12 hours. This medication was not administered to resident #3 on 7/13, 7/14, 7/20, 7/22, 7/25, 7/26, 7/27, 7/28, 7/29 or 7/30/19 because the medication was not available in the home.

Resident #7 is prescribed Doxepin at bedtime. This medication was not administered to resident #7 on 7/1, 7/2, 7/23/19 because the medication was not available in the home.

Resident #7 is prescribed Ibuprofen at bedtime. This medication was not administered to resident #7 on 7/1, 7/2/19 because the medication was not available in the home. Additionally, on 8/1/19 the medication was 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.)

Resident #7 no longer resides in community. Resident #3's Morphine, Alprazolam and Breo Elipta obtained for use. Staff re-trained on re-ordering medications timely, follow up with pharmacy, and notifying nurse immediately. MD to be notified of any missed doses of medication. Dir. of Residential Services to monitor for ongoing compliance (see attached)

Legal Entity Representative

Regina Heilman-Toth

Signature

REGINA HEILMAN-TOTH 9/13/19

Printed Name and Title Date

EXECUTIVE DIRECTOR

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

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

The above plan of correction is approved as of 03-11-2020 (Date)

Plan of correction implementation status as of 03-11-2020 (Date)

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

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

190a - Completion Medication Course

Regulations

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person D's last annual practicum was 02/2018. Two observations were done in February and May 2019, but no medication administration record review was done.

The home stated the Pharmacy Liason Nurse conducts the medication administration training for med-techs; however, the home did not provide a Train-the-Trainer certificate for the Pharmacy Liason Nurse.

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.)

Staff member D completed her MAR Review on 9/13/19. Quarterly observations, MAR reviews and annual practicums to be completed by a certified trainer on staff, and monitored by Director of Resident Services for ongoing compliance.

Legal Entity Representative

Regina Heilman-Toth — REGINA HEILMAN-TOTH 9/13/19

Signature — Printed Name and Title — Date

EXECUTIVE DIRECTOR

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

224a - Preadmission Screen Form

Regulations

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted to the home on 4/16/19. As of 7/31/19, the home did not complete a preadmission screening form for resident #1.

Resident #4 was admitted to the home on 7/11/19. As of 7/31/19, the home did not complete a preadmission screening form for resident #4.

Resident #5 was admitted to the home on 2/7/19. The preadmission screening form in resident #5's record was incomplete. The form was missing Part 1, who completed the form and when. Part 2 was missing the name and date of birth of the resident, the resident's means of communication, current residence information, ADL, IADL, sensory needs, medical psychological and behavioral diagnoses, and if the resident can safely use and avoid poisons.

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 #1and #4 no longer resides in community. Resident #5's Pre-Screen completed 8/7/19 . The admission process has been reviewed and revised. No resident will be admitted without having the Pre-screen and the DME completed. Marketing and nursing staff re-educated regarding this stipulation. The ED/ Director of Residential Services are responsible for ongoing compliance (see attached)

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH — Printed Name and Title

9/13/19 — Date

EXECUTIVE DIRECTOR

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

227h - Support Plan Refuse Sign

Regulations

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1 did not sign the support plan dated 04/17/19, and the home did not document that the resident was unable to sign or refused to sign the plan.

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 #1 no longer resides in community.
Nurse to review support plan with resident and family/POA. If resident unable to sign due to refusal or impaired cognitive ability nurse will document such findings

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH EXECUTIVE DIRECTOR — Printed Name and Title

9/13/19 — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

231b - Medical Evaluation

Regulations

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

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on 4/16/19. As of 7/31/19, the home failed to ensure a medical evaluation was complete for resident #1.

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 #1 no longer resides in community.

A DME will be completed prior to admission into the community for each resident. ED and RSD will be responsible for ongoing compliance (see attached)

Legal Entity Representative

Regina Heilman-Toth
Signature

REGINA HEILMAN-TOTH 9/13/19
Printed Name and Title EXECUTIVE DIRECTOR
Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

231c - Preadmission Screening

Regulations

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

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on 4/16/19. As of 7/31/19, the home failed to complete a cognitive preadmission screening for resident #1.

Resident #5 was admitted to the SDCU on 2/7/19. The preadmission screening form in resident #5's record was incomplete. Part 4 of the form or the cognitive screening was incomplete and did not document the resident's diagnosis, who completed the form or the date the screening was completed.

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 #1 no longer resides in community. Resident #5 had pre-screen completed 8/7/19. Admission process to include completed pre-screen, DME, and an updated SDCU form for all residents who will reside in the memory care unit. Marketing is to initiate obtaining documents for nursing review. Nursing/designee responsible for insuring that required documents are complete prior to admission. ED/DRS to monitor for ongoing compliance (see attached)

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH — Printed Name and Title

9/13/19 — Date

EXECUTIVE DIRECTOR

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

231e - No Objection Statement

Regulations

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on 4/16/19. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

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 #1 no longer resides in community.
SDCU form has been reviewed and revised. The form is currently included in the admission packet provided to family/resident and must be completed prior to admission. Marketing responsible to obtain signed document. When completed provide to nurse for maintaining in resident file. The ED/DRS to monitor for ongoing compliance (see attached)

Legal Entity Representative

Regina Heilman-Toth — Signature
REGINA HEILMAN-TOTH EXECUTIVE DIRECTOR — Printed Name and Title
9/13/19 — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

233c - Key-Locking Devices

Regulations

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

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to the SDCU, specifically the exit to the enclosed court-yard and to the fire stairwells.

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.)

Directions were posted immediately upon notification by surveyors. (7/31/19)
Going forward, the Maintenance Director is responsible for insuring that the directions remain conspicuously posted.

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH EXECUTIVE DIRECTOR — Printed Name and Title

9/13/19 — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

252 - Record Content

Regulations

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.

Description of Violation

Resident #4's record does not include a photograph of the resident.

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 #4 no longer resides in the community.
The Director of Activities is responsible for taking initial picture of residents upon admission; nursing staff verifies that it is completed and uploaded.
Going forward, an updated picture will be obtained annually.
ED/DRS to monitor for ongoing compliance

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH EXECUTIVE DIRECTOR — Printed Name and Title

9/13/19 — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

Violation Report

Facility Information

Name: *ALLEGRIA AT THE OAKS* License Number: *14367*
Address: *6400 HULMEVILLE ROAD,, BENSALEM, PA 19020*
County: *BUCKS* Region: *SOUTHEAST*

Administrator

Name: *REGINA HEILMAN-TOTH* Phone: *2157529140* Email: *AVI@SAGEHCP.COM*

Legal Entity

Name: *BENSALEM PCH LLC*
Address: *6400 HULMEVILLE ROAD, BENSALEM, PA, 19020*

Certificate(s) of Occupancy

Type: *I-1* Date: Issued By:

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *125* Waking Staff: *94*

Inspection

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

Inspection Dates and Department Representative

11/06/2019 - On-Site: Natasha Braswell, Sabrina Freeman

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *95* Residents Served: *74*

Secured Dementia Care Unit

In Home: *Yes* Area: *MEMORY CARE* Capacity: *36* Residents Served: *29*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *72*
Diagnosed with Mental Illness: *11*
Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *51*
Have Physical Disability: *0*

51 - Criminal Background Check

Regulations

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The criminal background check for staff person A, date of hire 4-24-19; was completed on 11-6-2019.

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 learning that PA E-Patch must be used for background checks at the inspection of July 31-Aug.1, 2019, each staff person whose check had been done by Sapphire was re-done by PA E-Patch on Aug. 5-6, 2019. Due to human error, Staff Member A, who had had a Sapphire check upon hire, was missed during this process of re-doing each background check. It was completed immediately and printed while the inspectors were on premises Nov. 6, 2019
2019.
Going forward the attached check list will be completed at the orientation of each new employee, indicating that the required background check has been completed.

Legal Entity Representative

Regina Heilman-Toth
Signature

REGINA HEILMAN-TOTH 12/12/19
Printed Name and Title EXECUTIVE DIR. Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☑ 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 #1 is prescribed Fish Oil Gummies 225 mg. However, resident #1 was administered Fish Oil Soft Gel 1200 mg from 11-1-19 to 11-6-19 at 8:00 am.

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 #1order for Fish Oil Gummies 225 mg was corrected immediately to reflect correct dose. Nurses and medication techs were re-educated and counseled in regard to strict adherence in following proper policy and procedures when administering medications.

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH 12/12/19
Printed Name and Title EXECUTIVE DIR — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

188b - Medication Error Reporting

Regulations

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 is prescribed Fish Oil Gummies 225 mg. However, resident #1 was administered Fish Oil Soft Gel 1200 mg from 11-1-19 to 11-6-19 at 8:00 am. The medication error was not reported to the Department.

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 discovery of medication error Nursing/Designee will immediately notify the resident, the resident's designated party and the prescriber of the error. Documentation of same, accompanied by prescriber's response will be maintained in Resident Record. The Executive Director/Designee will report error to the Department in a timely manner. Resident Services Director/Designee will conduct weekly audits on newly prescribed orders X4 weeks followed by monthly audits X4 months and quarterly thereafter to prevent future occurrences.

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH EXECUTIVE DIR. — Printed Name and Title

12/12/19 — Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

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

224a - Preadmission Screen Form

Regulations

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2's preadmission screening form, dated 10-10-19, does not include a determination that the needs of the resident can be met by the services provided by 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.)

Resident #5 Pre-Screen completed on 11/7/19. The Resident Services Director/Nursing Designee will complete a second check to ensure each section of the Pre-Screen is completed as required. ED/RSD are responsible for ongoing compliance. (See attached)

Legal Entity Representative

Regina Heilman-Toth — Signature

REGINA HEILMAN-TOTH 12/12/19
Printed Name and Title EXECUTIVE DIR. Date

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

The above plan of correction is approved as of 03-11-2020 (Date)

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

Plan of correction implementation status as of 03-11-2020 (Date)

- [x] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented