pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LAFAYETTE MANOR INC LMI**
LEGAL ENTITY

To operate **BEECHWOOD COURT AT LAFAYETTE MANOR**
NAME OF FACILITY OR AGENCY

Located at **145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA 15401**
(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 **64**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 23

Restrictions:

This certificate is granted in accordance with the Public Welfare 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 **October 3, 2019** until **October 3, 2020**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **409610**

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 628 – 7/19

pennsylvania
DEPARTMENT OF HUMAN SERVICES

October 3, 2019

Ms. Diana L. McGregor
Administrator
Lafayette Manor, Inc., LMI
145 Lafayette Manor Road
Uniontown, Pennsylvania 15401

RE: Beechwood Court at Lafayette Manor
Certificate #: 409610

Dear Ms. McGregor:

As a result of the Department's Bureau of Human Services Licensing annual inspection on August 20, 2019 and September 20, 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.

A regular license is being issued based on the enclosed violation report. Your license is enclosed.

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

Enclosures
License
Violation Report

Violation Report

Facility Information

Name: *BEECHWOOD COURT AT LAFAYETTE MANOR* License Number: *40961*
Address: *145 LAFAYETTE MANOR ROAD,, UNIONTOWN, PA 15401*
County: *FAYETTE* Region: *WESTERN*

Administrator

Name: *Diane McGregor* Phone: *7244346024* Email: *dmcgregor@lafayettemanor.net*

Legal Entity

Name: *LAFAYETTE MANOR INC LMI*
Address: *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA, 15401*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *09/27/2000* Issued By: *Dept of L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *64* Waking Staff: *48*

Inspection

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

Inspection Dates and Department Representative

08/20/2019 - On-Site: Scott Klein, Ashley Roser

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* Residents Served: *50*

Secured Dementia Care Unit

In Home: *Yes* Area: *Left Wing* Capacity: *23* Residents Served: *13*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *50*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *14*
Have Physical Disability: *0*

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 Pennsylvania Department of Health influenza poster is not posted in a public and conspicuous place in accordance with the Influenza Awareness Act, enacted in July 2016.

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 adminstrator did print from DOH website new flu posters and posted them in 4 places throughout the facility on 8/20/19. One is now posted in locked glass case in lobby.
Administrator and/or designee will do monthly checks to be certain flu poster is still in visable areas. On 8/29/19 a staff meeting was held and the staff was informed of this regulation includeing housekeeping staff.

Legal Entity Representative

Signature	Printed Name and Title	Date
Diana McGregor	Diana McGregor, Administrator	9/4/19

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

The above plan of correction is approved as of 9/16/19 (Date)

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

Plan of correction implementation status as of 10/2/19 (Date)

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

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Direct care staff person A did not complete training on Older Adult Protective Services Act (OAPSA) during the 2018 training year (1/1/18-12/31/18).

Repeat Violation 1/29/19 etal

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.)

Administrator has developed a new sign-off sheet for all annual trainings. See attachement # 1
Staff must now sign -off their own sheet as each training is completed.
Administrator then checks all sign-off sheets and does a certificate of training for each staff training completed. This system of double checks should help ensure that all mandatory trainings are completed. This system was put into effect beginning 1/19

Direct care staff A did complete the older protective services Act (OAPSA) on 8/21/19. see attachment # 7. Administrator will check all 2018 trainings immediately to ensure no other training is missing

Legal Entity Representative

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Diana McGregor	Diana McGregor, Administrator	9/4/19

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65i - Training Record

Regulations

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Direct care staff person B does not have a record of training that includes the staff person trained, date, source, content, and length of each course to meet the training requirements of 2600.65(a) and 2600.65(b).

Repeat Violation 1/29/19 etal

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.)

Administrator was able to get staff member B to sign the record of training sheet with a memo at the bottom of the page to confirm late signing. See attachement #2. All trainings were in staff file but not recorded on the record of training page.
Beginning immediately all trainings will be recorded on the record of training sheet immediately as training is completed for each new hire.

Administrator will check all new hires for correct training forms immediately upon hiring

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Diana McGregor	Diana McGregor, Administrator	9/4/19

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131f - Fire Extinguisher Inspection

Regulations

2600.

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

Description of Violation

All 11 of the home's fire extinguishers have not been inspected by a fire safety expert since 4/18.

The fire extinguisher in the home's activity van has not been inspected by a fire safety expert since 9/17.

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 Head of Maintenance was called immediately and he called Safety first. Safety first did come on 8/20/19 and inspect all fire extinguishers including the one in the activity van. See attachment #3 Safety first in the past has automatically come in for yearly checks, they stated that a filing error occured on their part. Since this error occured the Administrator will now write a calendar reminder to call Safety first in July of every year to remind them to come in August for yearly inspection.

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144c1 - Smoking Area Guidelines

Regulations

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area is enclosed within a free-standing structure with combustible wood building components. There is a wood bench measuring approximately 5 feet long by 3 feet wide used as furniture, and the plywood walls have burn marks from persons extinguishing cigarettes on the wood surface.

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 Administrator had the head of maintenance remove the bench from the smoking area on 8/20/19.
On or before September 30, 2019 the walls of the smoking structure will be removed leaving only the roof and posts. The posts will be covered with metal sleeves preventing anyone from extinquishing cig. on wooden surfaces. Also metal benches will be purchased to be used for furniture. See Attachement # 5.
Signs have been posted in the structure about not putting cigarettes out on walls until the walls can be removed See attachment #6

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171b5 - First Aid Kit

Regulations

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit located in the home's activity van does not have eye coverings, tweezers, scissors, or a thermometer.

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 Administrator did replace the missing items: eye covering, tweezers, scissors, and thermometer into the first aid kit in the activity van. They were replaced on 8/21/19.
The Activity Director will on a monthly basis check the first aid kit and ensure all items are present.
The first aid kit is now shut with a zip tie so if anything is used from the kit it will be known immediately and replaced promptly.

Legal Entity Representative

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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

Resident #2 is prescribed Levemir Flextouch Pen 100U/ML – Inject 25 units subcutaneously at bedtime. However, the pharmacy label indicates Inject 15 units subcutaneously at bedtime.

Resident #2 is prescribed Novolog Flexpen Inj 100U/ML - inject on sliding scale 201 to 250 = 2 units, 251 to 300 = 4 units, 301 to 350 = 6 units, 351 > = 8 units. However, the pharmacy label indicates Novolog Flexpen Inj 100U/ML – administer 3 times a day. Follow sliding scale on file at PCH.

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 uses mail order pharmacy, so the Administrative assistant who is responsible for mail order meds has been in touch with the pharmacy. She has obtained the information on how we can in the future get new labels for any order such as insulin that changes. The administrative assistant also had the PA-C write new scripts for both insulins to reflect changes and also to be certain that the sliding scale is also a part of the insulin label. The pharmacy has assured us that both changes will be on the labels and delivered to us by 9/20/19.

The administrative assistant will check monthly all labels to ensure accuracy of label to MAR and to physicians order

Legal Entity Representative

Diana McGregor	Diana McGregor, Administrator	9/4/19
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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

The home's policy for accounting of controlled substances states that all prescription medications must be counted and documented at any change of shift. However, resident #3's prescription for Morphine Sulfate 100mg/5mL – 0.25mL by mouth sublingually every 6 hours as needed for pain/breathing has not been counted and documented since 8/16/19.

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 Administrator has implemented a new narcotic count form. See Attachment #4.
The new procedure for counting narcotics went into effect on 9/1/19. Instead of signing one sheet at the end of a narcotic count now each narcotic has its own count sheet that must be signed as staff is counting the narcotics. This will ensure a more accurate count as well as ensure that all narcotics are being counted on each shift by two staff members

The administrator and/or designee will check monthly on all narcotic counts to ensure they are properly being counted and signed by staff

Legal Entity Representative

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- ☐ 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 #4 is prescribed Ondansetron 4mg tablet – take one by mouth or rectally every six hours as needed for nausea or vomiting. The medication was last filled on 3/13/19 and is not listed on the medication administration record.

Resident #4 is prescribed Furosemide 40mg 1 tablet by mouth every twelve hours as needed for edema. The medication was last filled on 5/8/19 and is not listed on the medication administration record.

Repeat Violation 1/29/19 etal

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 meeting was held between Amedysis Hospice, administrator and Administrative assistant on 8/26/19. This violation was discussed with them as these were medications ordered by hospice A protocol was set up for when meds are ordered through hospice. Hospice nurses will ensure that an order for any med is written and signed before they leave the facility to ensure that there is a written order for all meds. Supervisors will then ensure that the medication is properly added to MAR To further do checks a balances at a monthly meeting all mars of hospice patients will be double checked with orders from the hospice team. on 8/26/19 all mars and orders were checked and match

Legal Entity Representative

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Diana McGregor	Diana McGregor, Administrator	9/4/19

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- ☐ 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 Novolog Flexpen Inj 100U/ML - inject on sliding scale 201 to 250 = 2 units, 251 to 300 = 4 units, 301 to 350 = 6 units, 351 > = 8 units. On 8/9/19 at 3:53 p.m. the blood glucose reading was 251; however only 2 units of Novolog were administered.

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 Administrator has implemented a retraining for all staff on how to read a sliding scale insulin order. By 9/30/19 all staff will have been retrained and a copy of the training will be come a part of their yearly training file. The Dayshift supervisor does a monthly check of glucometer for calibration of date and time, she will now also be checking for accuracy of insulin given. A copy of these monthly checks is kept in Administrators office

Legal Entity Representative

Signature	Printed Name and Title	Date
Diana McGregor	Diana McGregor, Administrator	9/4/19

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226b - Mobility Requirements

Regulations

2600.

226.b. If a resident is determined to have mobility needs as part of the initial or annual assessment, specific requirements relating to the care, health and safety of the resident shall be met immediately.

Description of Violation

The assessment and support plan for resident #5 dated 7/25/19, indicates the resident is fully independent. However, the documentation of medical evaluation dated 7/25/19 indicates the resident is totally immobile.

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 Administrative assistant will be responsible for all assesments and medical evaluations, she will be the only staff person to do both forms. This will be in affect as of 9/1/19. In the past 1 staff person did assesments and the other did medical evaluations. To ensure that all info is correct only 1 staff member will do both. The administrator will then check both medical evaluation and assesments for accuracy.

The administrative assistant will check monthly to ensure that all documents are correct

Legal Entity Representative

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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 #3 was admitted to the home on 4/23/19. However, the resident's medical evaluation was completed on 4/25/19.

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 administrator has assigned the Admininstrative assistant the task of all medical evaluations. She has gone in the past to Penn State to take a course on medical evaluations and assesments To ensure accuracy of information and dates the administrative assistant will take over doing the forms on 9/1/19

The administrative assistant will immediately check all medical evalutations for accuracy and then will continue to do monthly checks to ensure all documentation is correct

Immediately: The administrator shall review all new resident admissions documentation to ensure compliance with regulation 2600.231(b). 10/2/19

Legal Entity Representative

Diana McGregor	Diana McGregor, Administrator	9/4/19
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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 #3 does not have a diagnosis of dementia and the resident's preadmission cognitive screening states that the resident does not need a secured dementia care unit.

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 was admitted with diagnosis of end stage lung cancer, he came from hospital on hospice. Resident at that time was able to work the key pad for secured unit. His condition worsened quickly and he was placed on active dying list with hospice. Beginning immediately Administrator and/or designee will do full assesment as to the residents ability to be in secured unit. Resident has since CTB while on Hospice.

Immediately: The administrator shall review all new resident admissions documentation to ensure compliance with regulation 2600.231(c). 9/16/19

Legal Entity Representative

Signature	Printed Name and Title	Date
Diana McGregor	Diana McGregor Administrator	09/04/19

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231g - Non-Dementia Admission

Regulations

2600.

231.g. An individual who does not have a primary diagnosis of Alzheimer's disease or other dementia may reside in the secured dementia care unit if desired by the resident.

Description of Violation

Resident #3 and resident #6 reside in the secured dementia care unit without a diagnosis of dementia and are unable operate the key locking device to exit the secured unit.

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 was able to use key pad when first admitted to secured unit. His medical condition quickly deteriorated and was placed on actively dying list for hospice and CTB on [redacted]/19. Resident #6 resided in the secured unit with her mother and mother has since CTB. Sister who has POA ask that she stay there since she has intelluctual disabilities and they are afraid with OCD she would not function out of unit. Staff has started to work with Resident #6 to teach her to use key pad Administrator is giving until October 1, 2019 that is one month and then will have a converstion with sister about moving resident to another room outside of secured unit.

Immediately: If resident #6 or any other resident who does not have a primary diagnosis of Alzheimer's or other dementia is unable to use the lock releasing device, the resident shall be placed in an area or home where the resident's needs can be met in accordance with the 2600 regulations. 9/16/19

Legal Entity Representative

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Diana McGregor	Diana McGregor, Administrator	9/4/19

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252 - Record Content

Regulations

2600.

252. Content of Resident Records - Each resident's record must include the following information:

3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident 3's record does not include a photograph.

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.)

Administrator has purchased for the facility an I-Pad that can be used to take residents photos this I-Pad is set up to transfer photos to tabula pro immediately. In the past the photos were taken with camera and then hooked to computer to trasfer to tabula pro.and/or taken to be developed With new system they can be done immediately upon admission. All Residents pictures were taken using the new process on 8/28/19 and transferred to records immediately

Upon admisision the administrator and/or designee will use i-pad to take residents picture immediately for files.

Legal Entity Representative

Diana McGregor — Signature

Diana McGregor Administrator 09/04/19 — Printed Name and Title / Date

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The above plan of correction is approved as of 9/16/19 (Date)

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

Plan of correction implementation status as of 10/2/19 (Date)

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

Received BHSL
9/27/19

Violation Report

Facility Information

Name: *BEECHWOOD COURT AT LAFAYETTE MANOR* License Number: *40961*
Address: *145 LAFAYETTE MANOR ROAD,, UNIONTOWN, PA 15401*
County: *FAYETTE* Region: *WESTERN*

Administrator

Name: *Diane McGregor* Phone: *7244346024* Email: *dmcgregor@lafayettemanor.net*

Legal Entity

Name: *LAFAYETTE MANOR INC LMI*
Address: *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA, 15401*

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *63* Waking Staff: *47*

Inspection

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

Inspection Dates and Department Representative

09/20/2019 - On-Site: Scott Klein, Ashley Roser

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* Residents Served: *49*

Secured Dementia Care Unit

In Home: *Yes* Area: *1st Floor Rear* Capacity: *16* Residents Served: *13*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *49*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *14*
Have Physical Disability: *1*

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 secured dementia care unit on 7/13/19. However, the resident's medical evaluation, completed on 7/13/19, does not indicate the need for the secured dementia care unit.

Resident #2 was admitted to the secured dementia care unit on 9/11/19. However, the resident's medical evaluation was completed on 11/21/18 and does not include the need for a secure dementia care unit.

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.)

Beginning September 20, 2019 the rasps and medical evaluations will be done by the same person, the administrative assistant will be responsible for these forms. With one person doing both forms it will make for better consistency and flow of information. The administrator will also check each one for accuracy. Resident #1 med eval was redone to indicate need for secured unit. See attachment #1. Resident #2 med eval also done to indicate need for secured and was done on the next work day after inspection. See attchment #2. In the future all forms will be done prior to any move to Secured unit

Legal Entity Representative

Diana McGregor — Signature

Diana McGregor Administrator 09/27/19 — Printed Name and Title / Date

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- ☐ 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 Secured Dementia Care Unit on 7/13/19. However, there is no cognitive screening completed for the resident.

Resident #2 was admitted to the secure dementia care unit (SDCU) on 9/11/19. However, the resident's cognitive screening was not completed until 9/18/19.

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.)

Administrator and/or administrative assistant will in the future ensure that all cognitive screens are completed before any resident is admitted to secure unit. no moves will be made without or until all forms have been completed and checked by administrator and/or administrative assistant. Resident # 1 cognitive screen was completed on the following business day after inspection. See attachment #3.

Legal Entity Representative

Diana McGregor — Signature

Diana McGregor Administrator 09/27/19 — Printed Name and Title / Date

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- ☐ Not Implemented