



Sent via e-mail rburns@hayesmanor.net
July 21, 2020

Ms. Robyn Burns
Administrator
Hayes Manor, Inc.
2210 Belmont Avenue
Philadelphia, Pennsylvania 19131

RE: Hayes Manor
License #: 142230

Dear Ms. Burns:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 14, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Claire Mendez

Claire Mendez
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: HAYES MANOR

License Number: 14223

Address: 2210 BELMONT AVENUE,, PHILADELPHIA, PA 19131

County: PHILADELPHIA

Region: SOUTHEAST

Administrator

Name: Robyn Burns

Phone: 2154731552

Email: robyn-elaine-burns@HAYESMANOR.NET

Legal Entity

Name: HAYES MANOR INC

Address: 2210 BELMONT AVENUE, PHILADELPHIA, PA, 19131

Certificate(s) of Occupancy

Type: Other

Date: 04/12/1985

Issued By: L&I

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 49

Waking Staff: 37

Inspection

Type: Full

BHA Docket #:

Notice: Unannounced

Reason: Renewal

Inspection Dates and Department Representative

01/14/2020 - On-Site: Youn Hie Chung, Dean Grey

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 65

Residents Served: 42

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 3

Are 60 Years of Age or Older: 42

Diagnosed with Mental Illness: 12

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 7

Have Physical Disability: 2

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 home's main hot water heater located in the basement is gas operated but there is no carbon monoxide detector installed not less than 15 feet away from the fossil fuel-burning device or appliance, as required by 35 P.S. 7241-Care Facility Carbon Monoxide Alarm Standards Act.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Signature *Hobyn Burns*

Printed Name and Title *Hobyn Burns, Adm*

Date *2/7/2020*

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

The above plan of correction is approved as of *3-11-2020*
(Date)

Plan of correction implementation status as of *7/17/2020*
(Date)

The above plan of correction was approved by *CM*
(Initials)

Implemented
 Not Implemented

Plan of Correction for 2600.18

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- Not exactly sure, probably the last time one of HVAC techs who services our system might have knocked it off?

Step 4 - Fix the immediate problem

- Our maintenance director immediately replaced the Carbon Monoxide Detector on January 14, 2020. He installed the new one and anchored it to the wall with screws to secure it. (pics enclosed)
- A daily checklist has been established to monitor that the carbon monoxide detector is in place and in proper working order by the maintenance personal and the department head on duty in their absence. (copy enclosed)
- All HVAC techs will be escorted at all times by the maintenance when checking the system.

Step 5 –Plan to ensure compliance

- Upon making rounds the administrator will monitor and observe weekly that the checklist is being completed, the carbon monoxide detector is in place and in proper working order for compliance.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Robyn Burns
Robyn Burns, Adm
2/7/2020

65f - Training Topics

Regulations

2600.

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

- 5. Personal care service needs of the resident.
- 7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in Personal Care Service Needs of the Resident or Care for Residents with MH or ID during training year 2019. The home serves residents with mental health issues.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Signature *Hobyn Burns*

Printed Name and Title *Hobyn Burns, Adm* Date *2/7/2020*

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The above plan of correction was approved by CM (Initials) Implemented Not Implemented

Plan of Correction for 2600.65.f

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- Upon HR completing the audit it was discovered that this employee had taken an extensive leave due to illness and was overlooked for this training?

Step 4 - Fix the immediate problem

- HR reviewed all employee files to identify anyone who did not receive this training or any of their annual trainings from 2019. This audit was completed by January 21, 2020.
- Any employee who had missed these two trainings and any other training were in-serviced by January 29, 2020. (Please see attached).

Step 5 –Plan to ensure compliance

- HR will review all employee files quarterly due to the high turnover in employees.
- The administrator will semi-annually audit all employee files.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Robyn Burns
Robyn Burns, Adm
2/7/2020

95 - Furniture and Equipment

Regulations

2600.

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

Description of Violation

The hinged folding lid of the home's ice machine in the main kitchen was held together with tape.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Dobyn Burns
Signature

Dobyn Burns, Adm
Printed Name and Title

3/7/2020
Date

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3-11-2020
(Date)

Plan of correction implementation status as of

7/17/2020
(Date)

The above plan of correction was approved by

CM
(Initials)

Implemented
 Not Implemented

Plan of Correction for 2600.95

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- No one reported to administration that the lid on the ice machine was broken. There has recently been a change in the leadership in dietary because it was needed.

Step 4 - Fix the immediate problem

- Keystone refrigeration was contacted to order a new lid on January 16, 2020. Keystone stated it would arrive in approximately 2 weeks because it would be shipped from outside of the country.
- They came in to remove the old one and install the new one on February 5, 2020. (Please see pics and invoice enclosed)

Step 5 –Plan to ensure compliance

- The new dietary manager and their assistant will inspect all equipment daily, and report to maintenance and the front office any hazards or equipment in need of repair or replacement.
- The administrator or department head on duty will observe equipment on rounds.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Hayes Burns
Hayes Burns, Adm
 2/7/2020

101j5 - Bedside Table/Shelf

Regulations

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside the resident' bed in bedroom #7.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Robyn Burns
Signature

Robyn Burns, Adm
Printed Name and Title

2/7/2020
Date

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(Initials)

Implemented
 Not Implemented

Plan of Correction for 2600.101.j

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The resident requested to have a smaller table in her room because at the time she had a queen-sized bed and her nightstand was too big, so the staff moved it for her. Since then she now has a hospital bed.

Step 4 - Fix the immediate problem

- On Wednesday January 15, 2020 the administrator explained the regulation to the resident and the need for compliance. The resident understood and agreed to have her light on her bedside table.
- Her bedside light is now back on her bedside table and can be turned on and off at bedside. (Please see enclosed pics.)
- All maintenance, housekeeping, and nursing staff have been informed of all lighting requirements and the reason for them. This information will also be provided to all new incoming staff members.

Step 5 –Plan to ensure compliance

- The administrator or department head on duty while making rounds will monitor all rooms for bedside tables and all required furnishings.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Hayes Burns
 Hayes Burns, Adm
 1/7/2020

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

The resident in bedroom #7 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Robyn Burns
Signature

Robyn Burns, Adm 2/7/2020
Printed Name and Title Date

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(Date)

The above plan of correction was approved by *CM*
(Initials)

- Implemented
- Not Implemented

Plan of Correction for 2600.101.j7

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The resident requested to have her light moved to the archway shelf in her room while she had her table moved.

Step 4 - Fix the immediate problem

- On Wednesday January 15, 2020 the administrator explained the regulation to the resident and the need for compliance. The resident understood and agreed to have her light on her bedside table.
- Her bedside light is now back on her bedside table and can be turned on and off at bedside. (Please see enclosed pics.)
- All maintenance, housekeeping, and nursing staff have been informed of all lighting requirements and the reason for them. This information will also be provided to all new incoming staff members.

Step 5 –Plan to ensure compliance

- The administrator or department head on duty while making rounds will monitor all rooms for bedside lights.

Signature of Legal Entity Representative -

Hayden Burns
 Hayden Burns, Adm
 5/7/2020

Printed Name and Title of Legal Entity Representative-

Date-

102e - Privacy - Doors/Partitions

Regulations

2600.

102.e. Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

Description of Violation

The common bathroom on the 1st floor had no lock, failing to provide privacy while being in use.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Signature *Hobyn Burns*

Printed Name and Title *Hobyn Burns, Adm* Date *8/7/2020*

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The above plan of correction was approved by CM (Initials) Implemented Not Implemented

Plan of Correction for 2600.102.e

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- After investigation because this issue had previously been addressed by the administrator, it was discovered that residents had gotten locked in a maintenance employee changed it out. This information was never reported to the administration.

Step 4 - Fix the immediate problem

- On Wednesday January 15, 2020 a new lock was installed (Pls. see enclosed pics.).
- A couple of days later the lock was broken again as well as the door.
- The door needed to be reframed to accommodate another lock. (Pics enclosed)
- Direct care staff will accompany and assist residents to use the common bathroom when needed to ensure privacy.
- They will also encourage the resident to use their own bathroom if privacy is a challenge.

Step 5 –Plan to ensure compliance

- The administrator or department head on duty while making rounds will monitor that the bathroom door lock is in place and properly working.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Robyn Burns
 Robyn Burns, Adm
 1/17/2020

103g - Storing Food

Regulations

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

Opened and unsealed packs of Turkey Burgers and of chicken breasts were in the freezer.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Hobyn Burns
Signature

Hobyn Burns, Adm of food
Printed Name and Title Date

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The above plan of correction was approved by CM (Initials) Implemented Not Implemented

Plan of Correction for 2600.103.g

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- Opened and unsealed items were in the freezer.

Step 4 - Fix the immediate problem

- All unsealed items were removed from the freezer and discarded immediately on January 14, 2020 by the new dietary director.
- All opened items were checked for proper storing by the director, this was completed January 15, 2020.
- All freezers have been cleaned out and re-organized to meet compliance. (Pls see pics enclosed)

Step 5 –Plan to ensure compliance

- The director will monitor that all freezer items are properly stored daily and, in her absence, this will be completed by the cook on duty.
- The administrator or department head on duty while making rounds will monitor the freezers for proper sealing and labeling of all items.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Handwritten signature: Mobyne Burns
 Mobyne Burns, Adm
 2/7/2020

103i - Outdated Food

Regulations

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There were 6 jars of unlabeled, undated condiments including cranberry sauce, grape jelly, Sauer Kraut, and etc. in the condiment refrigerator. There was a bag of diced chicken breasts and a bag of carrots without any labels in the freezer.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Robyn Burns
Signature

Robyn Burns, Adm
Printed Name and Title

7/17/2020
Date

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 (Date) Implemented (Date)
 The above plan of correction was approved by CM Not Implemented
 (Initials)

Plan of Correction for 2600.103.i

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- There were several items found undated and unlabeled in the refrigerator.

Step 4 - Fix the immediate problem

- All unlabeled items were removed from the refrigerator discarded immediately on January 14, 2020 by the new dietary director.
- A new container system was purchased on January 15, 2020. By January 17, 2020 all items in the refrigerator have been properly stored in the new system.
- All freezers have been cleaned out and re-organized to meet compliance.
(Pls see pics enclosed)

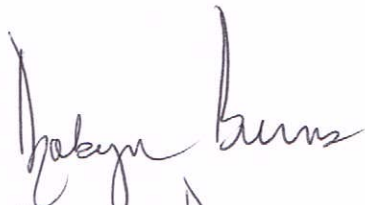
Step 5 –Plan to ensure compliance

- The director will monitor that all freezer items are properly stored daily and, in her absence, this will be completed by the cook on duty.
- The administrator or department head on duty while making rounds will monitor the freezers for proper sealing and labeling of all items.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-


Robyn Burns, Adm
2/7/2020

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

The Ansul fire suppression system in the kitchen has not been inspected by a fire safety expert since 12/2018.

Plan of Correction (POC)

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

Thobyn Burns
Thobyn Burns, Adm
2/7/2020

Legal Entity Representative

Signature

Printed Name and Title

Date

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(Date)

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(Date)

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

Implemented
 Not Implemented

Plan of Correction for 2600.131.f

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The Ansul fire suppression system was not inspected when Kartman Fire Protection Co. came in to do our annual recertification.

Step 4 - Fix the immediate problem

- On Wednesday January 15, 2020 Kartman Fire Protection Co. was contacted by the Maintenance director in regards of failing to inspect of kitchen Ansul system when they were in for our annual recertification.
- Kartman was in on Friday January 31, 2020 to inspect and tag the Ansul extinguisher. A copy of the document is enclosed. (Pls see pics)
- Maintenance will check all extinguishers monthly.

Step 5 –Plan to ensure compliance

- The director of maintenance will contact Kartman for inspection 90 days prior to the expiration date and will notify the administrator of the scheduled date.
- The administrator will observe extinguishers on rounds monthly.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Robyn Burns
 Robyn Burns, Adm
 2/7/2020

132e - Fire Drill Sleeping Hours

Regulations

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The fire drill conducted during sleeping hours was on 08/14/2018 at 05:53 AM. The next sleeping hours fire drill was conducted on 04/18/2019 at 06:14 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.)

Please see attached

Legal Entity Representative

Moby Burn
Signature

Moby Burns, Adm 7/17/2020
Printed Name and Title Date

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Plan of correction implementation status as of 7/17/2020
(Date)

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

Implemented
 Not Implemented

Plan of Correction for 2600.132.e

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The sleeping drill took place two months later than it should have been.

Step 4 - Fix the immediate problem

- A sleeping drill took place on Thursday January 16, 2020 at 10:10pm. (see enclosed)
- The maintenance director will schedule sleeping drills every five months for violation preventive measures.
- The maintenance director will review the drill documentation quarterly for compliance.

Step 5 –Plan to ensure compliance

- The administrator will track night timed drills to ensure that one is taking place at least every 6 months as regulated.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Robyn Burns
 Robyn Burns, Adm
 1/17/2020

132f - Alternate Exit Routes

Regulations

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The home used all exits during the fire drills held from January to December in 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.)

Please see attached

Legal Entity Representative

Robyn Burns
Signature

Robyn Burns, Adm
Printed Name and Title

8/7/2020
Date

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(Date)

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(Initials)

Implemented
 Not Implemented

Plan of Correction for 2600.132.f

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The maintenance director stated that he changed his previous way of documenting because he was told by the fire expert to do so.

Step 4 - Fix the immediate problem

- All required documentation concerning fire drills reviewed.
- Employee re-in-serviced on proper documentation and the purpose of using alternate exit routes for fire drills.
- Maintenance director made aware that there have been no changes in the regulations regarding fire safety. Also informed that any and all changes given by any outside sources must be reviewed by the administrator. Under no circumstances are we to accept changes to regulations unless written documentation is received from the Dept. of Human Services.

Step 5 –Plan to ensure compliance

- The administrator will monitor documentation monthly following each fire drill.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Mobyln Burns
Mobyln Burns, Adm
9/7/2020

141a 1-10 Medical Evaluation Information

Regulations

2600.

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

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

Description of Violation

Resident #1's medical evaluation dated 06/13/2019 did not include medical diagnoses or medical information pertinent to the diagnoses.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Mobyen Burns
Signature

Mobyen Burns, Adm 2/7/2020
Printed Name and Title Date

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The above plan of correction was approved by CM (Initials) Implemented Not Implemented

Plan of Correction for 2600.141.a

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The resident's medical evaluation did not include medical diagnosis on it.

Step 4 - Fix the immediate problem

- The DON completed an audit on January 29th to check that all resident's medical evaluations had their medical diagnosis on them or on the attachment if one was sent by their PCP.
- The DON will inspect all required information on medical evaluations upon receipt.
- Nursing will contact the PCP immediately if the form is not completed for any needed corrections or required additional information.
- The DON will check all residents' charts semi-annually when completing her auditing process.

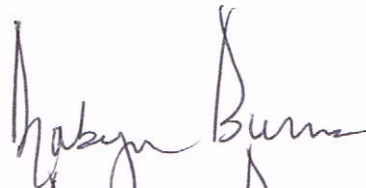
Step 5 –Plan to ensure compliance

- The administrator will observe all submitted medical evaluations monthly.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-


Robyn Burns, Adm
1/7/2020

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.
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 01/14/2020 at 12:10 PM, the med tech on duty filled multiple cups with multiple residents' medications, placed the cups on a tray, initialed the medication administration record, and then went to the dining room to disburse the medications.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Robyn Burns
Signature

Robyn Burns, Adm 7/17/2020
Printed Name and Title Date

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(Date) (Date)

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(Initials)

Plan of Correction for 2600.182.c

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The med tech on duty did not follow proper medication distribution according to regs.

Step 4 - Fix the immediate problem

- All med techs in-serviced on proper medication distribution and documentation during a med pass according to the regulations.
- All med techs observed during a med pass by the DON. This observation was completed on January 21, 2020.

Step 5 –Plan to ensure compliance

- The DON will continue to monitor quarterly and in-service all med techs on proper medication distribution and documentation according to regulation including identifying the resident, proper instruction and distribution of medications, how to properly document afterwards.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Robyn Burns
Robyn Burns, Adm
2/7/2020

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

On 01/14/2020 at 02:30 PM, Guaifenesin DM prescribed for resident #2 on an as-needed-basis was not available at 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.)

Please see attached

Legal Entity Representative

Signature: *Debyn Burns*

Printed Name and Title: *Debyn Burns, Adm* Date: *2/7/2020*

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The above plan of correction was approved by CM (Initials) Implemented Not Implemented

Plan of Correction for 2600.185.a

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- PRN medication was not available for a resident, but was listed on her MAR.

Step 4 - Fix the immediate problem

- Nursing completed an audit on January 15, 2020 on all medications available to residents against what was on the MAR.
- The lead charge nurse and the DON will be completing an audit monthly on the 2nd Wednesday of the month to verify all needed medication. They will also monitor the expiration dates of all PRN meds.
- They will re-order medications as needed or notify the PCP to discontinue meds if they are not used in 30 days or is no longer needed.

Step 5 –Plan to ensure compliance

- Medicare Pharmacy will conduct an audit semi-annually.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Hobyn Burns
Hobyn Burns, Adm
1/7/2020

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:

- 12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #3 is prescribed Aspirin 81 mg, Bupropion 75 mg and Prazosin 2 mg. However, the resident's medication administration record does not indicate the diagnosis of these medications.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Dobyn Burns
Signature

Dobyn Burns, Adm 7/7/2020
Printed Name and Title Date

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

The above plan of correction is approved as of 3-11-2020 (Date) Plan of correction implementation status as of 7/17/2020 (Date)

The above plan of correction was approved by CM (Initials) Implemented Not Implemented

Plan of Correction for 2600.187.a

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The MAR did not have diagnosis for three of three medications the resident was on.

Step 4 - Fix the immediate problem

- All current MAR's were checked by nursing to verify diagnosis for all ordered medications. This was completed by January 15, 2020.
- The pharmacy was contacted on January 15, 2020 regarding diagnosis on several MAR's and all was updated on January 16, 2020.
- The charge nurse will observe all MAR's when received from the pharmacy for the following months recaps.

Step 5 –Plan to ensure compliance

- The DON and Administrator will monitor all new MAR's while completing monthly recaps for all residents and make any needed corrections. They will also notify pharmacy with all corrections or updates when necessary .

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Robyn Burns
Robyn Burns, Adm
1/17/2020

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

Med tech on duty at 12:10 PM on 01/14/2020 had entered her initials before she actually administered the medications for multiple residents. Resident #4 is prescribed Atorvastatin 10 mg at bed time on Monday, Wednesday, and Friday. However, her MAR was initialed every day for this medication. Resident #5 is prescribed Accu-check once daily at 06:30 AM. However, it was not checked on 01/08, 01/09, 01/11, and 01/14/2020 at 06:30 AM but the staff initialed the MAR.

Repeat Violation: 07/22/2019 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.)

Please see attached

Legal Entity Representative

Dobyn Burns
Signature

Dobyn Burns, Adm 2/2/2020
Printed Name and Title, Date

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The above plan of correction is approved as of	<u>3-11-2020</u> (Date)	Plan of correction implementation status as of	<u>7/17/2020</u> (Date)
The above plan of correction was approved by	<u>CM</u> (Initials)	<input checked="" type="checkbox"/> Implemented <input type="checkbox"/> Not Implemented	

Plan of Correction for 2600.187.b

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- Med tech initialed meds prior to disbursement, the MAR for resident #4 did not block out days that they were not to be given, blood sugar was not completed on days that were initialed by staff.

Step 4 - Fix the immediate problem

- All med techs re-in-serviced on correct way to dispense medication and documentation regarding residents' medications. (see enclosed)
- All MAR's were checked by the DON to ensure that all medication scheduled times are correct and being documented accurately. This was completed by January 15, 2020. As our medications are pre-packaged by pharmacy the resident did not receive the medication, the error was that the MAR was not blocked off.
- A check system for residents receiving blood sugar checks has been established and will be checked weekly by the nursing staff. This will be a random check different days, times, and residents to ensure that the blood sugars are accurate and being completed as ordered. (Pls see included documentation)
- Med techs involved has been counseled any other issues regarding incorrect or falsification of documentation they will be terminated. (see enclosed)

Step 5 –Plan to ensure compliance

- The DON and Administrator will monitor all new MAR's while completing monthly recaps for all residents and make any needed corrections.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Debyn Burns
 Debyn Burns, Adm
 2/7/2020

187d - Follow Prescriber's Orders

Regulations

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #5 is prescribed Accu-check once daily at 06:30 AM. However, it was not checked on 01/08, 01/09, 01/11, and 01/14/2020 at 06:30 AM.

Repeat Violation: 12/07/2018 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.)

Please see attached

Legal Entity Representative

Hobyn Burns
Signature

Hobyn Burns, Adm *7/17/2020*
Printed Name and Title Date

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The above plan of correction is approved as of 3-11-2020 (Date) Plan of correction implementation status as of 7/17/2020 (Date)

The above plan of correction was approved by CM (Initials) Implemented Not Implemented

Plan of Correction for 2600.187.d

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The blood sugar was not completed on days that were initialed by med techs.

Step 4 - Fix the immediate problem

- All med techs re-in-serviced on correct way to dispense medication and documentation regarding residents' medications. (see enclosed)
- A check system for residents receiving blood sugar checks has been established and will be checked weekly by the lead charge nurse. This will be a random check different days, times, and residents to ensure that the blood sugars are accurate and being completed as ordered. (Pls see included documentation)
- Any and all discrepancies will be immediately reported to the DON and Adm in her absence.
- Med techs involved has been counseled any other issues regarding incorrect or falsification of documentation they will be terminated. (see enclosed)

Step 5 –Plan to ensure compliance

- The DON will review the check system monthly.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Debyn Burns
Debyn Burns, Adm
2/7/2020

190b - Insulin Injections

Regulations

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 01/01, 02, 04, 05, 06, 09, 10, 13/2020 at 04:30 PM, staff person B, who has not completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to resident #4.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Mobyen Burns
Signature

Mobyen Burns, Adm
Printed Name and Title

2/7/2020
Date

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The above plan of correction is approved as of

3-11-2020
(Date)

Plan of correction implementation status as of

7/17/2020
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

CM
(Initials)

Plan of Correction for 2600.190.b

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The med tech had not taken and passed an approved diabetic education program and was administering insulin.

Step 4 - Fix the immediate problem

- The employee was immediately removed from administering insulin injections.
- All other med tech employee files were audited on January 15, 2020 by HR and comply.
- The med tech completed and passed the diabetes education class on January 17, 2020 (copy of course and certificate enclosed)
- HR to include requirements for all new hire med techs on new hire orientation packet. Also, to get a copy of all documentation and certifications prior to their start of employment.

Step 5 –Plan to ensure compliance

- Front office personnel to monitor documentation for all new hire employees prior to their start date.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Robyn Burns
Robyn Burns
1/7/2020

225c - Additional Assessment

Regulations

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #4's most recent assessment was completed on 12/13/2018.
Resident #6's most recent assessment was completed on 06/28/2018.
Resident #7's most recent assessment was completed on 12/28/2018.

Plan of Correction (POC)

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

Please see attached

Legal Entity Representative

Robyn Burns
Signature

Robyn Burns, ADM *2/7/2020*
Printed Name and Title Date

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The above plan of correction is approved as of 3-11-2020 Plan of correction implementation status as of 7/17/2020
(Date) (Date)

The above plan of correction was approved by CM Implemented
(Initials) Not Implemented

Plan of Correction for 2600.225.c

Step 1 – Reviewed

Step 2 – Reviewed

Step 3 – Why did the violation happen?

- The annual assessments on resident #4, 6, and 7 had not been completed. Because of recent staffing issues some of the director's tasks were behind to meet the residents needs and she and the administrator helped on the floor. Since then direct care staffing needs have been fulfilled.

Step 4 - Fix the immediate problem

- The resident assessments on #4,6, and 7 were completed on January 14, 2020. (copy enclosed)
- All the other resident charts were audited for possible omissions by the DON, this was completed by January 17, 2020.
- Assessments are now being completed according to schedule.

Step 5 –Plan to ensure compliance

- The DON will monitor for needed assessments monthly.

Signature of Legal Entity Representative -

Printed Name and Title of Legal Entity Representative-

Date-

Hayes Burns
 Haydn Burns, Adm
 2/7/2020