Sent via e-mail jennifer.miller9@genesishcc.com
Sent via e-mail dennis.gregory@genesishcc.com
September 17, 2020

Ms. Jennifer Miller
Executive Director
600 Paoli Pointe Drive Operations, LLC
600 Paoli Pointe Drive
Paoli, Pennsylvania 19301

RE: Highgate at Paoli Pointe
License #: 136100

Dear Ms. Miller:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 7 and 11, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Mia Johnson

Mia Johnson
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *HIGHGATE AT PAOLI POINTE*
Address: *600 PAOLI POINTE DRIVE,, PAOLI, PA 19301*
County: *CHESTER* **Region:** *SOUTHEAST*
License Number: *13610*

Administrator

Name: *Jennifer Miller* **Phone:** *6102967100* **Email:** *jennifermiller9@genesishcc.com*

Legal Entity

Name: *600 PAOLI POINTE DRIVE OPERATIONS LLC*
Address: *600 PAOLI POINTE DRIVE, PAOLI, PA, 19301*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *03/04/1996* **Issued By:** *Commonwealth of PA Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *93* **Waking Staff:** *70*

Inspection

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

Inspection Dates and Department Representative

02/07/2020 - On-Site: Natasha Braswell, Tahesia Thomas
02/11/2020 - On-Site: Natasha Braswell, Tahesia Thomas

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *124* **Residents Served:** *59*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Memory Care* **Capacity:** *30* **Residents Served:** *23*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *2*
Have Mobility Need: *34*
Are 60 Years of Age or Older: *59*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

16c - Written Incident Report

Regulations

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 2-6-20 and 2-7-2020, resident #1 missed two days of medication. The home failed to report this 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.)

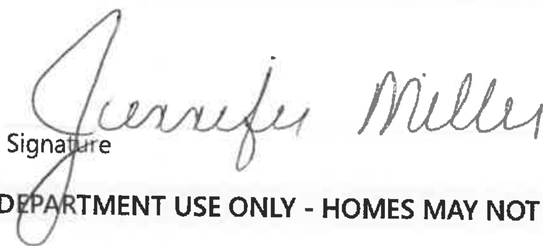
It is important to report all incidents to DHS per regulations. The Resident Care Director and the Memory Support Director were both re-educated on Reportable Incidents on 2/17/20.
See Attachement #1

Reportable Incidents will be reviewed during every QAPI meeting to ensure compliance.
See Attachment #2

All staff were re-educated on Reportable Incidents on 3/17/20 and 3/18/20
See Attachment #3

All employees receive training on Reportable Incidents during new hire orientation and annually thereafter.

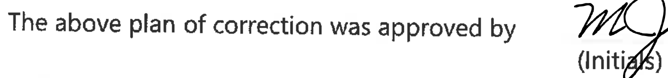
Legal Entity Representative



Signature

Jennifer Miller, Executive Director — Printed Name and Title

7/3/20 — Date



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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented

☐ Not Implemented

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

17 - Record Confidentiality

Regulations

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 2-7-2020, the Wellness room was unlocked, unattended, and accessible to the Department, two contractual employees and a laboratory technician. The Department representative advised the contractual workers and outside laboratory technician that staff was not present. The workers continued to go through files and the laboratory technician removed urine without signing any documentation of receipt.

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.)

It is important for the home to maintain confidentiality for all of our residents.

All staff were re-educated on 3/17/20 and 3/18/20 on confidentiality, resident chart access and keeping the nurse's station door locked when not in use.

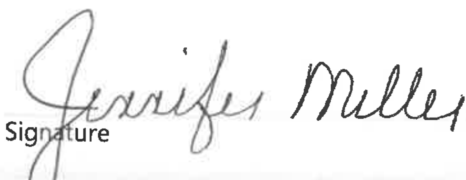
The lab, home care and hospice agencies were educated in reporting directly to the nurse supervisor or Resident Care Director upon arrival to the home.

The Resident Care Director is responsible for ensuring that the nursing staff maintain confidentiality and keep the nurse's station door locked.

The Executive Director conducts random checks weekly to ensure the door is locked and to monitor for ongoing compliance.

See attachment # 3

Legal Entity Representative



Signature

Jennifer Miller, Executive Director — Printed Name and Title

7/3/20 — Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by (Initials)

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

According to 34 Pa. Code Chapter 3, known as the Boilers and Unfired Pressure Vessels regulations. (governed by Department of Labor and Industry). If a home has a boiler, it must have a valid "Certificate of Boiler or Pressure Vessel Operation" issued by the PA Department of Labor and Industry. Upon expiration of the certificate, boilers must be inspected, and if they pass inspection, they will be issued a new certificate. The home was not able to locate the annual boiler certificate to ensure the boiler was operable condition.

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.)

It is important to ensure the home's boiler is inspected annually. The company contracted in 2019 has yet to provide a copy of the annual certification for 2019. The home's property management company has contracted with a new company, Chubb, to provide our annual inspection. Due to COVID 19, the company has not been able to come out to the home.

We are expecting the company to conduct inspection in August of 2020 as long as we remain COVID free.

The Maintenace Director will be responsible for ensuring the boiler is inspected annually and the certification is received in a timely manner. The certification will be kept in the home's licensing binder for accessibility.

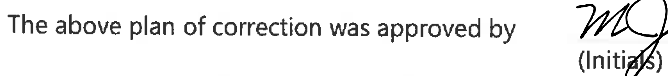
The Executive Director will monitor these inspections for ongoing compliance.

See Attachment # 4

Within 5 days receipt of new certificate the home will submitt a copy to the Department.

Legal Entity Representative

Signature — **Jennifer Miller, Executive Director** (Printed Name and Title) — **7/3/20** (Date)



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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

- [ ] Implemented
- [X] Not Implemented

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

26a - Quality Management Plan

Regulations

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home has not implemented it's quality management plan as it has not conducted a quality management review in over a year.

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 QAPI meeting was held on 2/19/20 to review QAPI guidelines and expectations with the new leadership team. New QAPI guidelines were implemented at that time.

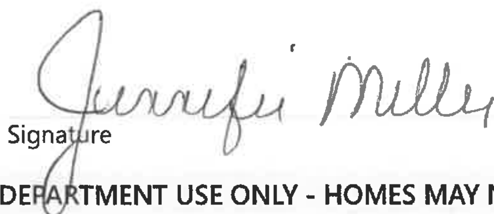
Type text here

QAPI will be held quarterly. QAPI was held again on 5/13/20. The next QAPI meeting is scheduled for July 8, 2020.

Starting January 2021, QAPI will be held on a monthly basis. The Executive Director will oversee these meeting to monitor for ongoing compliance.

See Attachments # 2 and 5

Legal Entity Representative



Signature	Jennifer Miller, Executive Director Printed Name and Title	7/3/20 Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by (Initials)

42b - Abuse

Regulations

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 1-1-2020, staff person A, neglected to properly care for resident #2, as demonstrated by the resident being in physical discomfort. The resident was observed by her daughter sitting with a heavily soiled personal product; that soaked through her clothing. Her colostomy bag was overfilled with waste. Staff person A failed to check on resident #2 and the home failed to train staff person A on colostomy care.

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.)

It is important that all residents are cared for appropriately and in a timely manner. All staff were re-educated on 3/17/20 and 3/18/20 on the following: resident care, RASPs, assignment sheets and following procedures.

To ensure proper oversight of nursing care, the home has updated its staffing pattern. Staffing now includes the addition of an LPN to personal care and to memory care on 1st shift, an LPN in personal care and in memory support on 2nd shift, and an LPN to cover the building on the 3rd shift.

Whenever a resident is admitted/re-admitted to the home with a colostomy bag, all nursing staff will be immediately educated on the proper care of the colostomy bag.

All nursing staff will review colostomy care during their annual competency testing in December 2020 and annually thereafter.

A procedure book was also implemented as a resource tool for staff to utilize - including how to care for a colostomy bag.

The Resident Care Director will be responsible for overseeing all residents with a colostomy or catherter to ensure proper nursing care is being completed in a timely manner.

The Executive Director will oversee resident care through observation, care plans and nursing notes to ensure ongoing compliance.

See attachments # 3, 6 and 7

Legal Entity Representative

Jennifer Miller

Signature

Jennifer Miller, Executive Director — Printed Name and Title

7/3/20 — Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

[X] Implemented

[ ] Not Implemented

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

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

Staff person A, hired 7-24-19, criminal background check was not completed until 8-15-19.

On 2-11-2020, there were two contractual painters in the home without the proper criminal background checks and without staff supervision.

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.)

It is important that any person working in the home have the required criminal background checks. The painters were immediately removed from the building.

The following process has been implemented to ensure compliance: The maintenance director will ensure that he has a copy of any contracted company's insurance information as well as criminal background checks on the employees entering the home.
All contracted employees will be required to sign in at the front desk and wear a Visitor's ID Badge. Maintenace staff will meet the employees at the front desk and escort them to their work area. A member of the maintenace team will remain in the vacinity to ensure oversight and supervision.

A Business Office Manager was hired to assist with all HR tasks. A new hire checklist was created and implemented in April 2020. This checklist includes ensuring that the home has a current criminal background check for a new employee prior to them attending orientation. This checklist is utilized for every new hire.

The Executive Director will complete random audits to ensure all paperwork is in place . Audits will be reviewed at QAPI to ensure ongoing compliance.

See attachment # 9 and 10

Legal Entity Representative

Signature	Printed Name and Title	Date
Jennifer Miller	Jennifer Miller, Executive Director	7/3/20

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

The above plan of correction is approved as of 8/20/20 (Date)

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

Plan of correction implementation status as of 8/20/20 (Date)

- [x] Implemented
- [ ] Not Implemented

54a - Direct Care Staff

Regulations

2600.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff persons B and C, do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeat Violation: 3/6/19 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.)

Administration immediately notified the employees for proof of education. Employee B employment ended with the home. Employee C's information is attached.

A Business Office Manager was hired to assist with all human resouce tasks. A new employee checklist was created and implemented in April of 2020 to ensure all required paperwork is submitted for a new employee prior to their first day of work. This checklist is utlized for every new hire and kept in their employee file.

The Executive Director and/or designee will conduct quarterly audits to ensure all required documentation is . Audits will be reviewed at QAPI to ensure ongoing compliance.

See Attachments #8, 9 and 10

Legal Entity Representative

Signature: [signature]

Jennifer Miller, Executive Director — Printed Name and Title

7/3/20 — Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

- [X] Implemented
- [ ] Not Implemented

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

60b - Additional Staffing

Regulations

2600.

60.b. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the home and the operation and management of the home.

Description of Violation

On 12-28-19, there was 1 medication technician providing medication for a census of 60 residents. Medications were administered late due to staffing. The home would benefit from additional staffing to ensure medications are given in a timely manner.

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.)

It is important to have the appropriate staffing levels to ensure proper care and medication administration for the residents in the home.

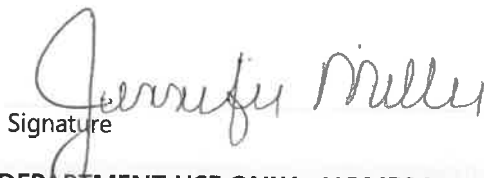
The home updated the staffing pattern to ensure medications are adminstered in a timely manner. An updated staffing pattern is attached. Additional nurses were permanently added to the staffing schedule in March 2020.

Both the Resident Care Director and Memory Support Director are also able to administer medications to assist as needed.

The Resident Care Director is responsible for ensuring appropriate staffing. The Resident Care Director and Executive Director meet Weekly to review staffing and ensure ongoing compliance.

See Attachment # 11

Legal Entity Representative



Signature

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by (Initials)

60c - Housekeeping/Maintenance

Regulations

2600.

60.c. Additional staff hours, or contractual hours, shall be provided as necessary to meet the laundry, food service, housekeeping and maintenance needs of the home.

Description of Violation

On 2-11-20, the housekeeping/maintenance department were short staffed. As demonstrated by the basic housekeeping duties not being completed in resident rooms; such as trash removal, unclean carpets, and soiled surfaces throughout the home. According to maintenance director, the services were not provided due to a lack of staff to complete the task.

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.)

It is important to have appropriate staffing to ensure all tasks are being completed. The home's housekeeping department is contracted with the company Healthcare Services. The company increased staffing to meet the home's needs.

Currently housekeeping's schedule is two (2) full time housekeepers, seven (7) days a week from 8 am to 4 pm. A Director of Housekeeping is present in the home five (5) days a week for oversight and assistance.

The Director of Maintenance will be responsible for direct oversight of the cleanliness of the building and will work with the Director of Housekeeping from Healthcare Services to ensure the home is clean.

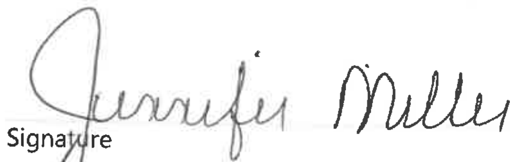
The Director of Maintenance and/or designee will conduct monthly cleanliness audits.

Type text here

The executive Director will review these audits during QAPI to ensure ongoing compliance.

See Attachments # 12 and 13

Legal Entity Representative



Signature

Jennifer Miller, Executive Director — Printed Name and Title

7/3/20 — Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented

☐ Not Implemented

The above plan of correction was approved by (Initials)

65d - Initial Direct Care Training

Regulations

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on 7/24/19, began providing unsupervised ADL services on 7/24/19. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until.

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.)

It is important that all employees complete the DHS Competency Test prior to their first day providing care in the home.

A new process has been implemented to ensure alll new nursing staff take this test prior to being assigned to resident care

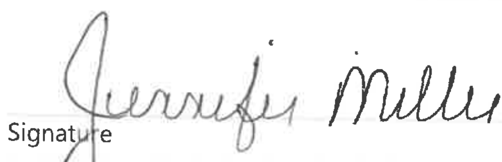
All new nursing staffing are required to complete the DHS Competency Test on day one of orientation. No employee is permitted to provide care unless the certification of completion is on file.

The Business Office Manager is responsible for ensuring all new hires complete this test on day one of orientation.

The Executive Director and/or designee will conduct quarterly audits of all employee files to ensure the certification is on file. These audits will be reviewed during QAPI to monitor for ongoing compliance.

See attachments # 10 and 14

Legal Entity Representative



Signature

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

65d - Initial Direct Care Training *(continued)*

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

The above plan of correction is approved as of 8/20/20 (Date)

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

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented

☐ Not Implemented

66c - Training Documentation

Regulations

2600.
66.c. Documentation of compliance with the staff training plan shall be kept.

Description of Violation

The home does not maintain documentation of the completion of courses in the staff training plan including colostomy care.

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.)

An immediate on the spot in-service will be conducted by the Resident Care Director and/or designeefor any resident's being admitted or returning to the home with a colostomy.

An annual competency skills test has been created for all nursing staff. This competency test will be conducted every December. The following dates will be the competency testing dates for 2020: 12/3/20, 12/4/20, 12/8/20 and 12/9/20.

The Resident Care Director will be responsible for the oversight of these competency skills testing/trainings.

The Exective Director will monitor for ongoing compliance.

See Attachment # 15

Legal Entity Representative

Signature

Jennifer Miller, Executive Director	7/3/20
Printed Name and Title	Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

- [x] Implemented
- [ ] Not Implemented

The above plan of correction was approved by (Initials)

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/11/20, at 10:40 am, the recliner in room #310 had a urine odor.

On 2/11/20, at 11:45 am, the toilet in room # 016 was stained with urine.

On 2/11/20, at 11:50 am, the toilet in room # 017 was not flushed and filled with urine.

On 2/11/20, while conducting the medication audit in both personal care and memory care, staff reported that gloves are not readily 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.)

It is important that the home's sanitary conditions be maintained. Healthcare Services increased the housekeeping staff in the home. There is now a housekeeper designated to memory suppory 7 days a week and a housekeeper designated to personal care 7 days a week. A Director of Housekeeping is in the building for assistance and oversight 5 days a week.

The Executive Director will work with families to replace any furniture that is soiled or emites an odor.

A supply room was created so that all staff had immediate access to all required supplies. The Resident Care Director is responsible for ensuring the supply room remains stocked by ordering anything needed on a weekly basis vis DSSI.

The Executive Director and/or designee will conduct random audits of the supply to ensure it is appropriately stocked and will monitor for ongoing compliance.

See Attachments # 16 and 17

Legal Entity Representative

Signature: Jennifer Miller | Printed Name and Title: Jennifer Miller, Executive Director | Date: 7/3/20

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented
☐ Not Implemented

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

85d - Trash Receptacles

Regulations

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 2-11-2020, at 11:00 am the trash can in the kitchen had a broken lid.

Plan of Correction (POC)

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

The Trash Can was immediately replaced.

The Director of Maintenance will be resposible for ensuring that any trashcans that are without a lid, are cracked, etc. will be immediately replaced.

The Executive Director will monitor for ongoing compliance.

See Attachment # 18

Legal Entity Representative

Signature: Jennifer Miller | Printed Name and Title: Jennifer Miller, Executive Director | Date: 7/3/20

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

- [X] Implemented
- [ ] Not Implemented

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

88a - Surfaces

Regulations

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/11/20, the kitchen floor in room #310, was sticky, in addition the carpet was unclean and not vacuumed.

On 2/11/20, the ceiling in room #305 was not in good repair and the carpet was soiled and stained.

On 2/11/20, the carpet in room #314, was visibly unclean.

On 2/11/20, the floor in the activity room was soiled and not mopped.

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.)

It is important for the home to maintain a clean environment at all times. Healthcare Services increased the staffing for housekeeping in the home. The 3rd floor, memory support, now has its own designated houskeeper, 7 days a week to ensure cleanliness.

The carpets are being removed from all rooms and being replaced with laminated flooring, making it easier to keep the resident's room clean. Every floor will be replaced throughout the remainder of 2020.

The Executive Director, Maintenance Director, Property Manager, and Marketing Director conduct bi-weekly walk-throughs of the building to review items to be repaired or replaced. A spreadsheet has been created and is updated as each task is completed. This will be an ongoing spreadsheet. The Executive Director will monitor for ongoing compliance.

See attachment #19

Legal Entity Representative

Signature: Jennifer Miller

Printed Name and Title: Jennifer Miller, Executive Director

Date: 7/3/20

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

The above plan of correction is approved as of 8/20/20 (Date)

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

Plan of correction implementation status as of 8/20/20 (Date)

[X] Implemented

[ ] Not Implemented

91 - Telephone Numbers

Regulations

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the kitchen.

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.)

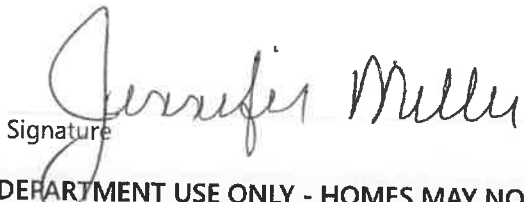
The label was immediately placed on the telephone.

The Maintenance Director and Memory Support Director and/or designee will be responsible for conducting quarterly audits to ensure all resident rooms and common areas meet regulatory requirements.

The Executive Director will review these audits durng QAPI to ensure ongoing compliance.

See Attachment # 13

Legal Entity Representative



Signature

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

101i - Access to Bedroom

Regulations

2600.
101.i. A resident shall have access to his bedroom at all times.

Description of Violation

On 2-11-20, rooms 303, 305 and 306 in memory care, were locked and inaccessible to the residents.

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.)

An audit was completed on 3/11/20 reviewing residents and whether or not they lock their doors. This audit was reviewed with staff to ensure they understood the residents' right to access their rooms. There are residents that prefer to have their doors locked as well as residents who prefer to have their door open at all times - their preferences have been added to their care plans for staff to follow.

The Memory Care Director will be responsible for ensuring the residents/families preferences are documented and implemented.

The Executive Director and/or designee will monitor for ongoing compliance.

See Attachment # 20

Legal Entity Representative

Signature: Jennifer Miller

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

- [X] Implemented
- [ ] Not Implemented

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

101q - Storage Space

Regulations

2600.

101.q. Space for storage of personal property shall be provided in a dry, protected area.

Description of Violation

The resident in room #016, had to store incontinence products in the shower.

The resident in room #315, had to store their walker inside the shower.

Plan of Correction (POC)

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

The resident in room 16 allowed staff to move incontinence products to the closet. When products arrive, staff put the items away in the closet for the resident. In room 315, the walker was stored in the shower as the resident was bedbound on hospice services. The walker was removed and staff were re-educated to store unused items in the therapy room or the supply/storage area.

These violations were also reviewed with all staff during the March In-services held on 3/17/20 and 3/18/20.

Quarterly audits have been created for the Memory Support Director to utilize to ensure ongoing compliance.

The Executive Director and/or designee will complete random room checks to monitor for ongoing compliance.

see attachments # 3 and 13

Legal Entity Representative

Signature	Printed Name and Title	Date
[signature]	Jennifer Miller, Executive Director	7/3/20

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

The above plan of correction is approved as of 8/20/20 (Date)

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

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented

☐ Not Implemented

102k - No Common Towel

Regulations

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

There were no paper towels, mechanical hand dryer or other sanitary means of hand drying in the male bathroom in the common area.

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.)

It is important that supplies are readily available in all bathrooms for proper hygiene.

There is now a designated housekeeper in memory support 7 days a week. The housekeeper will ensure supplies are in each bathroom at all times.

The Director of Memory Support will complete random bathroom checks weekly to monitor for ongoing compliance.

Legal Entity Representative

Signature	Printed Name and Title	Date
Jennifer Miller	Jennifer Miller, Executive Director	7/3/20

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

- [x] Implemented
- [ ] Not Implemented

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

103b - Clean/Sanitized Kitchen Surfaces

Regulations

2600.
103.b. Kitchen surfaces must be of a nonporous material and cleaned and sanitized after each meal.

Description of Violation

The refrigerator and freezer both displayed unclean sticky surfaces inside.

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.)

Healthcare Services increased staffing - allowing memory support to have a designated housekeeper 7 days a week on the unit. The houskeeper is now responsible for wiping down the refrigerator/freezer after each meal.

3rd shift nursing staff also have the assignment to wipe down the refrigerator/freezer each night.

The Director of Memory support will be responsible for ensuring the cleanliness of the kitchen as the quarterly audits are completed.

The Executive Director will review these audits during QAPI to monitor for ongoing compliance.

See attachment # 13

Legal Entity Representative

Signature [signature]

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

X Implemented
☐ Not Implemented

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

103c - Food Protected

Regulations

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 2-11-20, at 10:50 am, there were uncovered tubs of ice cream stored in the ice cream freezer located in the kitchen.

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.)

It is important that all food in the home remain covered at all time. The Dining Service staff were immediately re-educated on the importance of covering all food - especially the ice cream containers on 2/12/20.

The Dining Service Director is responsible for ensuring that the cooks check the freezer at the end of each day to ensure all food is properly contained.

The Executive Director will conduct random checks on the freezer to monitor for ongoing compliance.

Legal Entity Representative

Signature: Jennifer Miller | Jennifer Miller, Executive Director (Printed Name and Title) | 7/3/20 (Date)

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

- [X] Implemented
- [ ] Not Implemented

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

103d - Storing Food Off Floor

Regulations

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 2-11-20, at 10:50 am, the emergency water was stored on the floor in the kitchen.

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.)

Palettes were immediately purchased and the water is currently stored on these palletes. Maintenance staff were re-educated that all food items, including water, may not be stored on the floor without palettes per regulations. The Director of Mantenance will monitor for ongoing compliance.

See attachment # 22

Legal Entity Representative

Signature: [signature]

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

[X] Implemented
[ ] Not Implemented

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

183f - Discontinued Medications

Regulations

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 2/7/20, the following medications, Ipratropium Bromide, Cherry Halls, Quetapine Fumarate F/C 25 mg, Amlodipine Besylate, Diltiazem 24 240, Escitalopram 10mg, Aspirin EC 81 mg, Timoptic Ocudose belonging to resident #3 were observed in the wellness room, the resident moved out on 1-12-19.

On 2/7/20, the following medication Hydrochlorothiazide 40 mg belonging to resident #4 was observed in the wellness room. The medication was discontinued on 1-15-20.

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.)

It is important that all expired medications be destroyed according to regulations and the process put in place by the home.

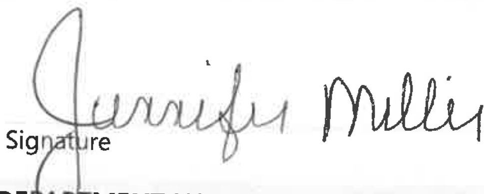
Nursing staff (nurses and med techs) were re-educated on medications and the destruction of medications on 2/26/20. Nursing staff are to utilize the Resident Discharge Checklist to ensure medications are destroyed at the time of discharge.

The Resident Care Director and Memory Support Director and/or designee will be responsible for completely quarterly medication audits to ensure there is no expired or old medications in the medication carts.

The Executive Director will review these audits during QAPI to ensure ongoing compliance.

See Attachments # 23, 24 and 30

Legal Entity Representative



Signature

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

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:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident #4's Combigan 5 ml 0.2% 0.5% and Montelukast Soduim does not include the resident name, name of the medication, date the prescription was issued, prescribed dosage, instructions for administration, and the name and title of the prescriber.

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 techs were re-educated on medication carts and medication labeling on 2/26/20.

All medications must be labeled appropriately and per regulations to ensure the safety of our residents. The home's pharmacy, Omnicare, came into the home and completed an audit of all medications on 3/4/20 to ensure all medication labels were correct.

Medication Cart audits are being completed by the Resident Care Director and the Memory Support Director.

Beginning July 2020, a medication cart audit will be completed monthly by the Resident Care Director, Memory Support Director and/or designee.

The Executive Director will review these audits during QAPI for ongoing compliance.

See attachments # 24, 25 and 26

Legal Entity Representative

Signature: Jennifer Miller

Jennifer Miller, Executive Director — Printed Name and Title

7/3/20 — Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

[X] Implemented

[ ] Not Implemented

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

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

On 2-11-20, a package of CVS stool softner and Miralax 17.9 oz 510 mg belonging to resident #4, was in the medication cart and 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.)

It is important to ensure all medications are properly labeled for the safety of all residents in the home.

Nurses and Med Techs were re-educated on medication carts and medication labels on 2/26/20.
The home's pharmacy, Omnicare, came onsite on 3/4/20 to complete a medication audit to ensure all medications were appropriately labeled and matched the MAR/Orders.

Medication Audits are being completed by the Resident Care Director and Memory Support Director.

Beginning July 2020, a medication audit will be completed monthly by the Resident Care Director, Memory Support Director and/or designee.

The Executive Director will review these audits during QAPI to ensure ongoing compliance.

Type text here

Legal Entity Representative

Signature: Jennifer Miller

Jennifer Miller, Executive Director — Printed Name and Title

7/3/20 — Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

- [x] Implemented
- [ ] Not Implemented

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

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 2-7-20, at 11:00 am, staff person D, was preparing to administer insulin; to resident #5 that was not stored at room temperature and was removed directly from the refrigerator.

On 2-11-20, at 10:00 am, the glucometer for resident #6 was not calibrated to the correct date and time.

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.)

It is important for the safety of our residents to ensure medications are administered correctly. The med tech observed was re-educated on insulin administration on 2/21/20.

Nurses (LPNs) have been added to each shift to ensure proper oversight of medication administration. All med techs receive annual diabetic training and certification.

The Resident Care Director will be responsible for conducting quarterly observations on medication administration by all nurses and med techs. As we currently have a new Resident Care Director, these observations will begin in July 2020 and will continue quarterly thereafter. .

A Glucometer audit has been created and implemented in July 2020. This audit will be completed monthly by the LPNs. The Resident Care Director and the Memory Support Director will monitor these audits to ensure completion.

These audits will be reviewed by the Executive Director duing QAPI meetings to ensure ongoing compliance.

See attachments # 27 and 31

Legal Entity Representative

Jennifer Miller

Signature

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

02/07/2020

185a - Implement Storage Procedures *(continued)*

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

The above plan of correction is approved as of 8/20/20 (Date)

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

Plan of correction implementation status as of 8/20/20 (Date)

- [x] Implemented
- [ ] 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 #4 is prescribed Alprazolam 0.25 mg tablet. However, resident's February 2020 medication administration record does not indicate the name and initials of the staff person administering the medication on 2/3/20.

Resident #7 is prescribed Oxycodone-Acetaminophen 5mg/325mg tablet. However, resident's February 2020 medication administration record does not indicate the name and initials of staff person administering the medication on 2/4/20 and 2/11/20.

Resident #8 is prescribed Aspercreme Lidocaine Max 4%. However, resident's February 2020 medication administration record does not indicate the name and initials of the staff person administering the medication on 2/1/20 and 2/2/20.

Resident #9 is prescribed Mirtazapine 7.5 tablet. However, resident's February 2020 medication administration record does not indicate the name initials of the staff person administering the medication on 2/9/20.

Resident #9 is prescribed Celexoxib 200 mg Capsule, Espomeprazole Magnesium 40 mg and Ferrous Sulfate 325 mg . However, resident's February 2020 medication administration record does not indicate the name and initials of the staff person administering the medication on 2/3/2020.

Resident #9 is prescribed Diclofenac Epolamine 1.3% Patch TD12. However, resident's February 2020 medication administration record does not indicate the name and initials of the staff person administering the medication on 2/2/20 and 2/3/20.

187a - Medication Record *(continued)*

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.)

It is important that all nursing staff administering medications, complete the required documentation. All nurses and medication techs were re-educated on 3/5/20 on medication administration, documentation, controlled substances, MAR signatures and medication errors.

The Resident Care Director and Memory Support Director are responsible for reviewing the MAR/TAR monthly to ensure all documentation is complete. If there are any discrepencies, staff will be immediately inserviced on the spot to ensure understanding and compliance.

The Executive Director will monitor for ongoing compliance.

See attachments # 28 and 29

Legal Entity Representative

Signature	Jennifer Miller, Executive Director Printed Name and Title	7/3/20 Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

- [X] Implemented
- [ ] Not Implemented

The above plan of correction was approved by (Initials)

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 Amiodarone HCL 200 mg, Eliquis 2.5 mg, Vitamin B-12 100 MCG, Miralax Powder, Omeprazole 20 mg, Senna 8.6 mg, Tramadol HCL 50 mg, Xtandi 40 mg and Acetaminophen 650 mg ER. However, these medications were not administered to resident #1 on 2/6/20 and 2/7/20 because the medications were not available in the home.

Plan of Correction (POC)

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

The home's pharmacy, Omnicare, came onsite on 3/4/20 to complete a medication audit to ensure all medications were appropriately labeled and matched the MAR/Orders.

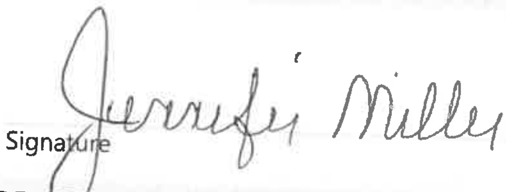
All prescribed medications must be in the home for all residents. All nurses and med tech were re-educated on medications on 3/5/20.

Medication Audits are being completed by the Resident Care Director and Memory Support Director

Beginning July 2020, a medication audit will be completed monthly by the Resident Care Director, Memory Support Director and/or designee.

The Executive Director will review these audits during QAPI to ensure ongoing compliance.

Legal Entity Representative



Signature

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented
☐ Not Implemented

The above plan of correction was approved by

(Initials)

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 Amiodarone HCL 200 mg, Eliquis 2.5 mg, Vitamin B-12 100 MCG, Miralax Powder, Omeprazole 20 mg, Senna 8.6 mg, Tramadol HCL 50 mg, Xtandi 40 mg and Acetaminophen 650 mg ER. Resident #1 was not administered these medication on 2/6/20 and 2/7/20, at 8:00 am and 4:00 pm because the medications were not available. The medication error was not reported to the resident, the resident's designated person, nor the physician.

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.)

It is important to follow regulations and report any medication errors to DHS, the resident, the designated person and the PCP.

All nursing staff were re-educated on medication errors on 3/5/20.

Medication errors and Reportable Incidents will be reported on at each QAPI meeting by the Resident Care Director and the Memory Support Director.

The Executive Director will monitor for ongoing compliance.

See Attachments # 28 and 2

Legal Entity Representative

Signature [signature] Jennifer Miller, Executive Director — Printed Name and Title — 7/3/20 Date

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

The above plan of correction is approved as of 8/20/20 (Date)

Plan of correction implementation status as of 8/20/20 (Date)

X Implemented

☐ Not Implemented

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

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.
    5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
    6. The name, address and telephone number of the resident's physician or source of health care.
    7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
    8. A list of prescribed medications, OTC medications and CAM.
    9. Dietary restrictions.
    10. A record of incident reports for the individual resident.
    11. A list of allergies.
    12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
    13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
    14. A support plan.
    15. Applicable court order, if any.
    16. The resident's medical insurance information.
    17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
    18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
    19. An inventory of the resident's property entrusted to the administrator for safekeeping.
    20. The financial records of residents receiving assistance with financial management.
    21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
    22. Copies of transfer and discharge summaries from hospitals, if available.
    23. If the resident dies in the home, a copy of the official death certificate.
    24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
    25. A copy of the resident-home contract.
    26. A termination notice, if any.

Description of Violation

Resident #10's record does not include the death certificate.

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.)

It is important to have death certificates on file of residents. An audit was created for the nurse supervisor to complete upon the death of a resident.

The Resident Care Director and the Memory Support Director will be responsible for ensuring this checklist is completed and for reviewing all documentation before a resident's chart is placed in medical records.

The Executive Director will oversee for ongoing compliance.

252 - Record Content *(continued)*

Legal Entity Representative

Signature

Jennifer Miller, Executive Director
Printed Name and Title

7/3/20
Date

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

The above plan of correction is approved as of 8/20/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 8/20/20 (Date)

☒ Implemented
☐ Not Implemented