pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: kley@concordialm.org

MAILING DATE: April 9, 2020

Ms. Kimberly Ley
Administrator
Concordia Lutheran Ministries of Pittsburgh
1300 Bower Hill Road
Pittsburgh, Pennsylvania 15243

RE: Concordia at the Cedars
4363 Northern Pike
Monroeville, Pennsylvania 15146
License / COC #: 446240

Dear Ms. Ley:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 21, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Jon B Kimberland

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: CONCORDIA AT THE CEDARS
License Number: 44624
Address: 4363 NORTHERN PIKE,, MONROEVILLE, PA 15146
County: ALLEGHENY Region: WESTERN

Administrator

Name: Kim Ley Phone: 4123733900 Email: kley@CONCORDIALM.ORG

Legal Entity

Name: CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH
Address: 1300 BOWER HILL ROAD, PITTSBURGH, PA, 15243

Certificate(s) of Occupancy

Type: C-1 Date: 08/19/1998 Issued By: Department of Health

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 90 Waking Staff: 68

Inspection

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

Inspection Dates and Department Representative

02/21/2020 - On-Site: Scott Klein, Belinda Graziano, Barb Barone

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 87 Residents Served: 69

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 6

Number of Residents Who:

Receive Supplemental Security Income: 0
Are 60 Years of Age or Older: 69
Diagnosed with Mental Illness: 0
Diagnosed with Intellectual Disability: 0
Have Mobility Need: 21
Have Physical Disability: 0

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

At approximately 3:00 p.m., there was a bin in the first-floor lobby next to the elevator. The bin contained the license inspection summary, dated 8/7/19, with the privacy coding document attached to include the names of residents #1, #2, #3, #4, #5, and #6. The bin also contained the license inspection summary, dated 10/24/19, with the privacy coding sheet still attached to include the name of resident #7.

At approximately 4:35 p.m. in the first floor hall way on the left side of the med cart outside of resident room #106, was a green binder labeled "1st floor narcotic record" which was unlocked, unattended, and accessible with multiple resident names and the names of the medication to include resident #8, Oxycontin & APAP 5/325mg tablets, resident #6, Gabapentin Capsule 100mg, and resident #9, Lorazepam 0.5mg tablet.

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.)

License bin on the first floor had both privacy coding forms removed on February 21, 2020. The first floor medication cart is now storing the narcotic record binder inside the narcotic drawer.

The administrator will complete an audit on March 11, 2020 to identify any other records that are not confidential. Any identified records will have immediate corrective actions taken.

The RCC will educate the nursing assistants, medication technicians and licensed practical nurses on the regulation.
The PC administrator and/or designee will weekly audit the facility for confidential information not being stored appropriately. This audit will be completed weekly for three months. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

K Ley — Signature

Kimberly Ley PCHA — Printed Name and Title

3-6-2020 — Date

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

The above plan of correction is approved as of 3/9/2020 (Date)

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

Plan of correction implementation status as of 3/31/2020 (Date)

☒ Implemented

☐ Not Implemented

23a - Activities of Daily Living Assistance

Regulations

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan for resident #6 dated 11/1/19 indicates the resident will receive assistance from staff related to toileting as needed. However, on 12/7/19, during a company party, resident #6 was left unattended for approximately 1 hour on the toilet in the resident's private bathroom while requesting assistance using the home's call bell system.

Plan of Correction (POC)

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

Resident #6 assessment and support plan will be reviewed upon his return to the personal care home. Resident #6 will be received care as indicated on his assessment and support plan.

The PC administrator will educate the nursing assistants, medication technicians and Licensed Practical Nurses on the regulation 2600 23.3

The PC administrator and/or designee will complete call bell audits weekly for three months to validate resident assessment and support plans are being implemented. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

K A Ley
Signature

Kimberly Ley PCHA 3-6-2020
Printed Name and Title Date

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☐ Not Implemented

65e - 12 Hours Annual Training

Regulations

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A did not receive any of the required 12 hours of annual training during the 2019 training year.

Repeat Violation 8/7/19 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.)

Direct care staff person A will receive the required 12 hours of annual training before she is scheduled to work on the unit.

The PC administrator and/or designee will complete an audit of current employees to validate current staff have the required 12-hour training. Identified employees without required training will have immediate corrective actions taken.

The PC administrator and/or designee will audit 25% of current employees' files monthly to determine compliance with the 12-hour annual training requirement. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

KLey — Signature

Kimberly Ley PCHA 3-6-2020 — Printed Name and Title / Date

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☐ Not Implemented

65f - Training Topics

Regulations

2600.

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

Description of Violation

Direct care staff person A did not receive annual training in required topics for the 2019 training year to include:

(1) Medication self-administration training.

(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

(3) Care for residents with dementia and cognitive impairments.

(4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

(5) Personal care service needs of the resident.

(6) Safe management techniques.

Repeat Violation 8/7/19 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.)

Direct care staff person A has received the required 12 hours of annual training effective which includes: medication self-administration, instruction on meeting the needs of the resident as described in the preadmissions screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control, personal care service needs of the resident and safe management techniques before employee A is scheduled to work on the unit.

The PC administrator and/or designee will complete an audit of current employees to validate current staff have the required 12-hour training. Identified employees without required training will have immediate corrective actions taken.

The PC administrator and/or designee will audit 25% of current employees' files monthly to determine compliance with the 12-hour annual training requirement. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Signature

Kimberly Ley RCHA

Printed Name and Title

3-6-2020

Date

65f - Training Topics (continued)

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☒ Implemented

☐ Not Implemented

65g - Annual Training Content

Regulations

2600.

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Direct care staff person A did not receive required annual training for the 2019 training year to include:

(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.

(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.

(3) Resident rights.

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

(5) Falls and accident prevention.

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.)

Direct care staff person A has received the required 12 hours of annual training on fire safety, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act, Falls and accident prevention before employee A is scheduled to work on the unit.

The PC administrator and/or designee will complete an audit of current employees to validate current staff have the required 12-hour training. Identified employees without required training will have immediate corrective actions taken.

The PC administrator and/or designee will audit 25% of current employees' files monthly to determine compliance with the 12-hour annual training requirement. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

KaLey — Signature

Kimberly Ley EM 3-6-2020 — Printed Name and Title / Date

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☐ Not Implemented

82c - Locking Poisonous Materials

Regulations

2600.

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

Description of Violation

At approximately 12:10 p.m. in the wall bin of the private bathroom in resident room 100 belonging to resident #10, a 28 fluid ounce spray bottle of DG Home Fabric Refresher, approximately one fifth full, with a label that indicates "if swallowed, contact poison control center immediately" was found unlocked and accessible. Resident #10's assessment and support plan dated 3/15/19 indicates that the resident is unable to safely use and avoid poisonous materials.

Repeat Violation 8/7/19 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.)

Resident #10 had the 28-fluid ounce spray bottle of DG Home Fabric Refresher removed from the private bathroom on February 21, 2020.

The RCC and/or designee will complete an audit in the facility to identify any other poisonous material that is not locked up. Any identified material will have immediate corrective actions taken.
The RCC will educate the nursing assistants, medication technicians and licensed practical nurses on the regulation 82. C.

The RCC and/or designee will complete an environmental audit weekly to validate compliance with regulation 82.c. This audit will be completed weekly for 3 months and then monthly thereafter. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Signature

Kimberly Ley PCHA 3-6-2020
Printed Name and Title Date

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☒ Implemented
☐ Not Implemented

85a - Sanitary Conditions

Regulations

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

Description of Violation

At approximately 9:00 a.m., the first floor corridor outside of and inside room #100 had a very pungent odor of urine.

Repeat Violation 8/7/19 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.)

Room #100 will have the flooring replaced which will eliminate the odor of urine. Bid from Pennsylvania Floors Corp attached.

The RCC and/or designee will complete an audit in the facility to identify any other area that has a urine odor. Any identified area will have immediate corrective actions taken.
The RCC will educate the nursing assistants, medication technicians and licensed practical nurses on the regulation 85. A.

The RCC and/or designee will complete an environmental audit weekly to validate compliance with regulation 85.a This audit will be completed weekly for 3 months and then monthly thereafter. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

KCaley — Signature

Kimberly Key PCHA — Printed Name and Title

3-6-2020 — Date

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☒ Implemented
☐ Not Implemented

85e - Trash Outside Home

Regulations

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 2:54 p.m., the home's dumpster area, had two loveseats and one couch sitting on the ground next to the dumpsters.

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 two loveseats and one couch have been removed from the campus. Pictures attached.

The PC Administrator will educate the housekeeping and maintenance staff on the regulation 85 e.

The maintenance director and/or designee will audit the outside trash receptacles three times a week for three months to validate compliance with the regulation. After three months the audit will be completed on a weekly basis. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

K Ley — Signature

Kimberly Ley PCHA — Printed Name and Title

3-6-2020 — Date

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- [x] Implemented
- [ ] Not Implemented

92 - Windows

Regulations

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At approximately 11:00 a.m., resident room #215 had is a hole in the lower left side of the window screen measuring approximately 2 inches by ½ inch.

Plan of Correction (POC)

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

Resident room #215 window screen was replaced on February 21, 2020. Picture attached.

The facility will complete a window screen audit on March 11, 2020 to identify any other affected rooms. Identified rooms will have corrective actions.
The PC administrator will educate the nursing assistants, medication technicians and licensed practical nurses on the regulation 92.

The PC administrator and/or designee will audit the window screens on a twice a month schedule to validate compliance with the regulation. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Kayley — Signature

Kimberly Ley PCHA — Printed Name and Title

3-6-2020 — Date

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☒ Implemented
☐ Not Implemented

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

There was no operable source of light at bedside in resident room #203 for resident #11.

There was no operable source of light at bedside in the shared resident room #215 for resident #1 and resident #12.

Plan of Correction (POC)

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

Resident #11, #1 and #12 as of February 21, 2020 have operable source of light at bedside.

The RCC and/or designee will complete an audit on current patient rooms on March 11, 2020 to validate operable source of light at bedside. Any rooms identified without an operable source of light at bedside will have corrective actions taken.

The RCC and/or designee will educate the licensed practical nurses, medication technicians and nursing assistants on regulation 101j7.

The PC administrator and/or designee will complete a room audit weekly to validate compliance with the regulation. This audit will be completed weekly for three months and then monthly thereafter. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Kadey — Signature

Kimberly Ley PCHA — Printed Name and Title

3-6-2020 — Date

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☒ Implemented

☐ Not Implemented

132b - Safety Inspection/Fire Drill

Regulations

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home does not have documentation of a fire safety inspection and fire drill conducted by a fire safety expert for 2019. The last documented supervised drill by the fire safety expert is dated 11/5/18.

Plan of Correction (POC)

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

The facility will have a fire safety inspection and fire drill conducted by a fire safety expert on March 23, 2020.

The PC administrator will educate the maintenance director on the regulation 132 b.

The PC administrator will validate the fire inspection and fire drill are scheduled yearly by auditing the schedule on a quarterly schedule. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

The home shall have a fire safety inspection and a fire drill conducted by a fire safety expert completed within 60 of the date the Disaster Proclamation is lifted by the Governor as indicated in the Department's Licensing Regulation Suspension: Personal Care Homes (2600) dated March, 29. 2020. 3/31/2020

Legal Entity Representative

K Lacey — Signature

Kimberly Lacy PCHA 3-6-2020 — Printed Name and Title / Date

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☒ Implemented

☐ Not Implemented

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

141a - Medical Evaluation

Regulations

2600.

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

Description of Violation

Resident #11, admitted 10/23/19, did not have a medical evaluation within 60 days prior to admission, or within 30 days after admission. There is no documentation of medical evaluation in the resident's record.

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.)

141. a

Resident #11 will have a medical evaluation completed on March 11, 2020.

The PC Administrator and/or designee will audit new admissions from January 1st to present to validate medical evaluations have been completed per the regulation. Identified residents without medical evaluations will have immediate corrective actions.

The PC administrator will educate the RCC on the regulation 141.a

The PC Administrator and/or designee will audit new admissions on a weekly basis for three months and monthly thereafter to validate the medical evaluation is completed according to the regulation. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Signature

Kimberly Ley PCHA 3-6-2020

Printed Name and Title Date

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☒ Implemented

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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

The initial medical evaluation for resident #13, dated 10/23/19, does not include the resident's height, that section was left blank.

Plan of Correction (POC)

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

Resident #13 will have a medical evaluation completed by March 11, 202 which includes resident's height.

The PC Administrator and/or designee will audit new admissions from January 1st to present to validate medical evaluations have been completed per the regulation. Identified residents without medical evaluations, which are complete will have immediate corrective actions. The PC administrator will educate the RCC on the regulation 141.a 1-10

The PC Administrator and/or designee will audit new admissions on a weekly basis for three months and monthly thereafter to validate the medical evaluation is completed according to the regulation. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Signature

Kimberly Ley PCHA — Printed Name and Title

3-6-2020 — Date

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☒ Implemented

☐ Not Implemented

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

The annual medical evaluation for resident #10, completed on 3/5/19, does not indicate whether or not the resident can safely use or avoid poisonous materials, and does not indicate the resident's height, that section was left blank.

Resident #9 had a medical evaluation completed on 11/30/18. However, the resident's next medical evaluation was not completed until 2/7/2020.

Resident #1 had a medical evaluation completed on 11/27/18. However, the resident's next medical evaluation was not completed until 1/20/2020.

Resident #6 had a medical evaluation completed on 4/16/18. However, the resident's next medical evaluation was not completed until 10/6/19.

Plan of Correction (POC)

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

The PC administrator and/or designee will audit current patients in house on March 11, 2020 to determine if any residents were affected with not having an annual assessment completed in 2019.

Any identified residents will have immediate corrective action taken. Current residents will have a medical evaluation completed in 2020 to start a new annual cycle.
The PC Administrator will educate the RCC on the regulation.

The RCC will establish a tracking tool with current patients listed and the date of their medical evaluation and the date for the next year's medical evaluation. The PC Administrator will audit current patients monthly to validate annual medical evaluations are completed per the regulation. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Signature

Kimberly Ley PCHA 3-6-2020
Printed Name and Title Date

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☐ Not Implemented

183d - Prescription Current

Regulations

2600.

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

Description of Violation

The medication administration record for resident #9 indicates Atenolol 50 mg tablet (25mg) Orally One time daily starting on 1/23/2018, was discontinued as of 2/6/2020. However, on 2/21/2020 at approximately 2:35 p.m. the Atenolol 50 mg tablets were stored in the home's medication cart.

Plan of Correction (POC)

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

Resident #9's Atenolol medication was removed from the medication cart on 2-21-20.

The facility's pharmacy will complete an audit on the medication carts to identify any other affected residents. Identified residents will have immediate corrective actions taken.
The RCC will educate the medication technicians and licensed practical nurses on the regulation.

The RCC will audit the medication carts on a weekly schedule to validate discontinued medications have been removed from the medication cart. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Signature

Kimberly Ley RCHA 3-6-2020
Printed Name and Title Date

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224a - Preadmission Screen Form

Regulations

2600.

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

Description of Violation

The home did not complete a pre-screening form for resident #11 admitted on 10/23/19.

The home did not complete a pre-screening form for resident #13 admitted on 10/24/19.

Plan of Correction (POC)

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

The PC administrator and/or designee will complete a preadmission screen on current PC referrals as of this date 3-25-20.

The PC administrator will educate the RCC on the regulation.
The PC Administrator and/or designee will complete a preadmission screen form on each referral received for the unit. If the patient does not admit within the 30day the administrator and/or designee will complete another preadmission screen form on the referral.

Designee will audit on a weekly basis compliance with this regulation. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Signature

Kimberly Ley PCHA 3-6-2020
Printed Name and Title Date

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The above plan of correction is approved as of 3/9/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/31/2020 (Date)

☒ Implemented
☐ Not Implemented

225a - Assessment 15 Days

Regulations

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #13, admitted 10/24/19, does not have an initial assessment completed.

Plan of Correction (POC)

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

Resident #13 written initial assessment is complete.
The PC Administrator will audit new admissions from the date of 3-25-2020 to validate there is an written initial assessment completed within 15 days of admission.

The PC Administrator will educate the RCC on the regulation.

The PC administrator will audit new admissions on a weekly basis to validate the written initial assessment is completed on the department's assessment form within 15 days of admission. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Signature

Kimberly Ley PCHA — Printed Name and Title

3-9-20 — Date

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The above plan of correction is approved as of 3/10/2020 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 3/31/2020 (Date)

☒ Implemented
☐ Not Implemented

225c - Additional Assessment

Regulations

2600.

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

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

The home completed a significant change assessment for resident #9 on 2/9/2020, to include hospice services. However, hospice services began for resident #9 on 1/13/2020.

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 facility will initiate additional assessments on the date the significant change was initiated.
The facility will review the clinical notes and orders on 3-18-2020. to determine if any significant change assessments are required on that date. If any resident is identified in this audit, they will have corrective actions taken.

The PC Administrator will educate the RCC on the regulation.

The RCC and/or designee will review nurses notes and physician orders weekly to determine if any significant change assessments are required on the date of the condition change. Results of this audit will be shared at the quarterly assessment and assurance committee meeting.

Legal Entity Representative

Signature | Kimberly Ley PCHA (Printed Name and Title) | 3-9-20 (Date)

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The above plan of correction is approved as of 3/10/2020 (Date)

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

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☒ Implemented

☐ Not Implemented