pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: jwkpch2@comcast.net

MAILING DATE: October 13, 2020

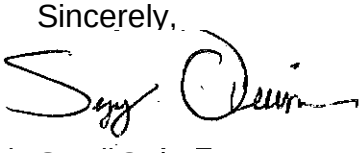
Mr. Jerry W. Kelly
President
Kelly's II Personal Care Home, Inc.
141 Unity Cemetery Road
Latrobe, Pennsylvania 15650

RE: Kelly's II Personal Care Home
Certificate #: 448400

Dear Mr. Kelly:

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,



Suzy Quinn
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED
4/30/20
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *KELLY'S II PERSONAL CARE HOME* License Number: *44840*
Address: *141 UNITY CEMETERY ROAD,, LATROBE, PA 15650*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: *DARLENE KELLY* Phone: *7248045916* Email: *JWKPCH2@COMCAST.NET*

Legal Entity

Name: *KELLY S II PERSONAL CARE HOME INC*
Address: *141 UNITY CEMETERY ROAD, LATROBE, PA, 15650*

Certificate(s) of Occupancy

Type: *R-3* Date: *03/05/2010* Issued By: *L&I*
Type: *C-2 LP* Date: *05/15/1992* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *9* Waking Staff: *7*

Inspection

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

Inspection Dates and Department Representative

02/21/2020 - On-Site: Joe Eveges

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* Residents Served: *8*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *4*

Number of Residents Who:

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

3c - Post Current License

Regulations

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The most home's most recent licensing inspection summaries, dated 9/11/19 and 4/3/19, are not posted in a conspicuous and public place in the home.

Plan of Correction (POC)

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

Corrected at time of inspection

- Supervisor will hang up most recent licensing inspection summaries immediately after receiving them from the state. Then is to ensure it doesn't get forgotten.

Immediately, then at least monthly, the administrator or designated staff person shall check the home to ensure all the current license, a copy of the current licensing inspection summary issued by the Department and a copy of Chapter 2600 are posted in a conspicuous and public place in the e home. Documentation of inspections shall be submitted to the Department.

SE 7/15/20

By 7/31/20, all staff shall be reeducated regarding the requirement that the home shall post the current license, a copy of the current licensing inspection summary issued by the Department and a copy of Chapter 2600 in a conspicuous and public place in the personal care home. Documentation of education shall be submitted to the Department.

SE 7/15/20

Legal Entity Representative

Signature Darlene Kelly Printed Name and Title DARLENE KELLY ADMINISTRATOR Date 4/24/20

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

The above plan of correction is approved as of 7/15/20 (Date)

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

Plan of correction implementation status as of 10/8/20 (Date)

✓ Implemented

Not Implemented

51 - Criminal Background Check

Regulations

2600.

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

Description of Violation

The home has no record of a criminal background check for direct care staff A, hired 12/1/19.

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.)

-Staff A is no longer employed at Kelly's II PCH.

By 7/31/20, the administrator or designated staff person shall audit all current staff records to ensure a completed criminal history check is on file. Any missing criminal history checks shall immediately be obtained. Documentation of audits shall be sent to the Department.

SE 7/15/20

By 7/31/20, all staff involved in the hiring process shall be reeducated regarding the requirement that criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. § 10225.101-10225.5102) and 6 Pa.Code Chapter 15(relating to protective services for older adults). Documentation of training shall be sent to the Department.

SE 7/15/20

Legal Entity Representative

Signature Darlene Kelly Printed Name and Title DARLENE KELLY ADMINISTRATOR Date 4/24/20

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Plan of correction implementation status as of 10/8/20 (Date)

✓ Implemented

Not Implemented

54a - Direct Care Staff

Regulations

2600.

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

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 person A, hired 12/1/19, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeat Violation: 9/11/19

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.)

By 7/31/20, the home shall submit to the Department documentation of staff person A s high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

SE 7/15/20

By 7/31/20, the administrator shall develop and implement a system to ensure that all newly hired staff persons have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry before providing any direct care services in the home. Documentation shall be submitted to the Department.

SE 7/15/20

By 7/31/20 and then at least monthly, the administrator or designated staff person shall audit all current staff records to ensure all direct care staff persons have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry in accordance with 2600.54.a. Documentation of the audit shall be submitted to the Department.

SE 7/15/20

Staff person A is no longer employed.

SE 10/8/20

Legal Entity Representative

Signature | Printed Name and Title | Date

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Plan of correction implementation status as of 10/8/20 (Date)

☑ Implemented

☐ Not Implemented

The above plan of correction was approved by SE (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:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired 12/1/19, did not complete and pass the Department-approved direct care training course and pass the competency test.

Repeat Violation: 9/11/19

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.)

Immediately, staff person A shall not provide unsupervised direct care until obtaining a Direct Care Staff Training Course and Competency Certificate of Completion. If staff person A obtains certificate, documentation shall immediately be sent to the Department.

SE 7/15/20

By 7/31/20, the administrator or designated staff person shall review all training records to ensure all direct care staff persons providing unsupervised direct care have a Direct Care Staff Training Course and Competency Certificate of Completion on file. Any direct care staff who do not have a Direct Care Staff Training Course and Competency Certificate of Completion on file, shall not be permitted to provide unsupervised direct care until obtaining the Certificate. Documentation of the audit shall be submitted to the Department. ew employee files shall be audited prior to the employee providing unsupervised direct care to ensure compliance with this regulation. Documentation of audits shall be kept.

SE 7/15/20

Staff person A is no longer employed.

SE 10/8/20

Legal Entity Representative

Signature | Printed Name and Title | Date

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Plan of correction implementation status as of 10/8/20 (Date)

- [x] Implemented
- [ ] Not Implemented

94b - Non-Skid Surface

Regulations

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

There is no non-skid material on the stairs of the front fire escape, leading from the 2nd floor office door to the front parking lot.

There is no non-skid material on the ramp leading from the kitchen exit to the side driveway/parking lot.

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.)

Per the administrator, code enforcement was onsite and stated the fire escape is not necessary and can be removed. By 7/31/20, the home shall submit written documentation from code enforcement to the Department. Per the administrator, the home is in the process of having the fire escape removed. Daily, until the fire escape has been removed, a designee shall inspect the area around the fire escape to ensure it is free of hazards. Documentation shall be submitted to the Department.

SE 7/15/20

on-skid strips have been installed on the ramp leading from the kitchen e it to the side driveway/parking lot.

SE 7/15/20

Immediately, then at least monthly, a designated staff person shall inspect all interior stairs, e terior steps and ramps to ensure they have nonskid surfaces. Any deficiencies discovered shall immediately be reported to the administrator and immediately repaired or replaced. Documentation shall be submitted to the Department.

SE 7/15/20

Legal Entity Representative

Signature | Printed Name and Title | Date

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- [x] Implemented
- [ ] Not Implemented

95 - Furniture and Equipment

Regulations

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

2 slats are missing and 2 slats are detached from the bottom base board of the wooden fire escape landing directly outside of the door leading from 2nd floor office to the front fire escape landing. Additionally, the bottom base board is dry rot and the paint on the entire landing and rails is worn, cracked and chipping away, posing a possible skin tear hazard.

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 owner put back up the missing slats + re-nailed the 2 that detached.
- On March 20, 2020 Unity Township code enforcement was called. Meryl will be out on May 8th as to how to proceed with tearing off the wooden fire escape + putting up metal ladder fire escape. His number is 724-422-7393. Because of the coronavirus he cannot come anytime sooner. When we are told what to do, we will notify you immedrately
- We have temporarily roped off those steps with caution tape + put Do not enter sign.

Legal Entity Representative

Per the administrator, code enforcement was onsite and stated the fire escape is not necessary and can be removed. By 7/31/20, the home shall submit written documentation from code enforcement to the Department. Per the administrator, the home is in the process of having the fire escape removed. Daily, until the fire escape has been removed, a designee shall inspect the area around the fire escape to ensure it is free of hazards. Documentation shall be submitted to the Department SE 7/15/20

Signature Darlene Kelly Printed Name and Title DARLENE KELLY ADMINISTRATOR Date 4/24/20

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Plan of correction implementation status as of 10/8/20 (Date)

✓ Implemented

Not Implemented

103e - Left Overs

Regulations

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled and undated chocolate cheesecake in the kitchen refrigerator.

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.)

- Corrected at time of inspection.
- The midnight shift made the chocolate cheesecake that morning and after it cooled daylight was going to label it for use at that day's lunch. But in meantime the inspector showed up & it was not done.
- Staff will immediately date every food item before it even goes into refrig./freezer. This is to ensure it doesn't get forgotten if staff gets into doing something else.

7/15/20

By 7/31/20, staff shall be re-educated as listed above. Documentation of education shall be submitted to the Department. SE

Immediately and at least daily, a designated staff person shall inspect all refrigerators and freezers to ensure all leftovers are labeled and dated. Any unlabeled or undated leftovers discovered shall immediately be disposed of. Documentation of inspections shall be sent to the Department.

Legal Entity Representative. SE 7/15/20

Signature Darlene Kelly

Printed Name and Title DARLENE KELLY ADMINISTRATOR

Date 4/24/20

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✓ Implemented

Not Implemented

103i - Outdated Food

Regulations

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

Description of Violation

A dented 20 ounce can of pineapple slices was in the cupboard next to the kitchen sink.

Plan of Correction (POC)

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

Staff will check can goods to ensure none are dented prior to putting them away. In future, Staff was told to throw away immediately any cans that are found with dents.

The dented can was disposed of during the inspection.

SE 7/15/20

Immediately, then at least daily, all food storage areas, shall be inspected and any dented cans, food that outdated, spoiled, or is not dated and the home does not have some other method of conclusively determining when the food was purchased, shall be discarded. Documentation of inspections shall be submitted to the Department.

SE 7/15/20

By 7/31/20, all staff persons involved in food preparation, serving and storage shall be reeducated regarding the requirement that outdated or spoiled food or dented cans may not be used, to include any food that is not dated and the home does not have some other method of conclusively determining when the food was purchased. Documentation of education shall be submitted to the Department

SE 7/15/20

Legal Entity Representative

Signature Darlene Kelly Printed Name and Title DARLENE KELLY ADMINISTRATOR Date 4/24/20

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Plan of correction implementation status as of 10/8/20 (Date)

✓ Implemented
Not Implemented

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

132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's maximum safe evacuation time specified in writing within the past year by a fire safety expert is 3 minutes 59 seconds. However, the fire drill conducted on 8/12/19 at 6:08 a.m. had an evacuation time of 4 minutes 45 seconds.

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 fire drill on 8/12/19 was longer than the allotted time of 3min 59 sec. due to unforseen circumstances due to a resident being in bathroom having a BM. Supervisor was unaware staff was still in bathroom w/ that resident. Staff have been reminded that fire drills are to be under 3 min 59 sec & in future to use redirection + prapting to get residents outside in timely manner.

Due to COVID-19, Governor Wolf signed an emergency Disaster Declaration on 3/6/20. As a result, regulation §2600.132(d) was suspended. The suspension shall end when Governor Wolf ends the Disaster Proclamation, unless OLTLL has stated a different time or unless OLTLL later sets another time. Immediately after the suspension is lifted, and monthly thereafter, the administrator or designated staff person shall conduct fire drills to evacuate all residents to a public thoroughfare or a designated fire-safe area within the time specified in writing by the fire safety expert within the past year. Documentation of all fire drills shall be kept in accordance with §2600.132(c). SE 7/15/20

Legal Entity Representative

Immediately following each fire drill, the administrator or designated staff person shall review the fire drill record to ensure all residents evacuate to a public thoroughfare or a designated fire-safe area within the time specified in writing by the fire safety expert within the past year. If the home exceeds the safe evacuation time specified in writing by a fire safety expert within the past year, the home shall add additional staff to the regular schedule and maintain the increased staffing level at all times and, if applicable, relocate residents who require special assistance with evacuation closer to exits or designated fire safe areas. Documentation of fire drill log reviews shall be kept for Department review.

Signature Darlene Kelly SE 7/15/20 Printed Name and Title DARLENE KELLY ADMINISTRATOR Date 4/24/2

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The above plan of correction is approved as of 7/15/20 (Date)

Plan of correction implementation status as of 10/8/20 (Date)

✓ Implemented

Not Implemented

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

141b1 - Annual Medical Evaluation

Regulations

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

Description of Violation

Section #7 "Medications" is blank on resident #2's annual medical evaluation, dated 3/30/19. In addition, the medication addendum on page 2 indicates "See attached"; however, no document is attached.

Section #7 "Medications" indicates "See Attached" on resident #3's annual medical evaluation, dated 1/21/20. However, no document is attached.

Repeat Violation: 4/3/19

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.)

Staff will ensure the doctor actually attaches the document listing the medications. Staff will check DME's after receiving them from doctor to make sure it's filled out in its entirety, including med list, before putting in resident file.

By 7/31/20, the home shall submit to the Department medication attachments for resident #2 & resident #3's DMEs.

SE 7/15/20

By 7/31/20 and monthly thereafter, the administrator or designated staff person shall audit all resident records to ensure an in-person medical evaluation has been conducted within the past year, is complete, to include medication attachments, and present in all resident files. If an annual medical evaluation was due on or after 3/6/20 and is not completed, documentation from the resident s primary care physician that the medical evaluation can be conducted at a later date determined by the physician provided that, the medical evaluation must be performed no later than 90 days after the Emergency Declarations is lifted, must be on file, or a new evaluation must be completed immediately.

Legal Entity Representative

SE 7/15/20

Signature Darlene Kelly

Printed Name and Title DARLENE KELLY ADMINISTRATOR

Date 4/24/20

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

Plan of correction implementation status as of 10/8/20 (Date)

✓ Implemented

Not Implemented

183b - Meds and Syringes Locked

Regulations

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

2 bottles of resident #3's Vancomycin 125mg/5ml medication were unlocked, unattended and accessible in the door shelf of the kitchen refrigerator.

Repeat Violation: 9/11/19

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.)

- Corrected at time of inspection
- Staff was reminded to lock up any & all medications. Not just narcotics. Staff thought because the medication was an antibiotic not a narc that it was okay. Staff was reminded/informed that is not the case.
- Staff immediately at time of inspection took the Vancomycin out of fridge & locked it in lock box in laundry room refrigerator.

☆ Note that resident 3 is not currently on the Vancomycin anymore. Excela hospice discontinued it on April 14, 2020.

Legal Entity Representative SE 7/15/20

Immediately, then at least daily, a designated staff person shall inspect all areas of the home, to include the kitchen refrigerator, to ensure prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked. Any unlocked medications discovered shall immediately be secured in an area or container that is locked. Documentation of inspections shall be submitted to the Department.

Signature | Printed Name and Title | Date

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

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

Plan of correction implementation status as of 10/8/20 (Date)

✓ Implemented

Not Implemented

184a - Labeling OTC/CAM

Regulations

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

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

Resident #4 is prescribed Systane 0.4-0.3% eyedrops – instill 1 drop 3 times daily into both eyes. However, the medication label indicates - Systane 0.4-0.3% - put 1 or 2 drops in the affected eye as needed.

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.)

- Corrected at time of inspection.
- Staff put a "see MAR for direction change" sticker on the Systane eyedrops immediately. This will alert staff (med aide) to follow directions in MAR not on eyedrop box. Staff was told to use these stickers anytime the label/box doesn't match the MAR.

Immediately, then at least monthly, a designated staff person qualified to administer medications shall audit prescription medications to ensure they are stored in their original container and labeled with a pharmacy label in accordance with 2600.184a. The pharmacy label and the MAR shall be compared to the prescriber s order. Any discrepancies discovered shall be verified with the prescriber and immediately corrected. Documentation of audits shall be submitted to the Department.

Legal Entity Representative SE 7/15/20

Signature Darlene Kelly Printed Name and Title DARLENE KELLY ADMINISTRATOR Date 7/24/20

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

Plan of correction implementation status as of 10/8/20 (Date)

✓ 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 #3 is prescribed Eucerin Intensive Repair Lotion – apply topically to bilateral lower extremities 2 times/day. However, this medication is not documented on the resident's February 2020 MAR.

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.)

By 7/31/20, the home shall submit to the Department an updated copy of resident #3 s MAR, including Eucerin Intensive Repair Lotion.

– Staff will compare latest month's MAR with the new month to ensure they match before putting them in binder for first day of new month.

– If something they are currently taking is not on new MAR, then staff will add it on.

See 7/15/20

By 7/31/20, all staff persons qualified to administer medication shall be reeducated on the information required to be present on all resident MARs in accordance with 2600.187a, to include immediately adding newly prescribed medications to the MAR upon receipt of the prescribers order. Any prescribed medications not listed on resident MAR's, or any missing medication information discovered, shall immediately be reported to the administrator and added to the resident MAR. Documentation of education shall be submitted to the Department.

See 7/15/20

Legal Entity Representative

Immediately, then at least monthly, the administrator or designated staff person qualified to administer medications shall audit all physician orders and resident MARs to ensure all required information for all medications is indicated on resident MARs. Documentation of audits shall be submitted to the Department.

See 7/15/20

Signature Darlene Kelly

02/21/2020

Printed Name and Title DARLENE KELLY ADMINISTRATOR

Date 4/24/20

187a - Medication Record *(continued)*

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Plan of correction implementation status as of 10/8/20 (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 #4's initial medical evaluation, dated 12/16/19, indicates multiple diagnoses to include brachycardia sinus, aortic ectasia and vitamin D deficiency; however, her initial assessment, dated 12/16/19, does not address these diagnoses.

Plan of Correction (POC)

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

Supervisor will in future include all diagnoses from DME in the RASR also. Staff will use DME when completing the assessment to ensure all diagnoses get listed.

By 7/31/20, the home shall submit to the Department an updated assessment for resident #4 which accurately reflects the resident s medical diagnoses. SE 7/15/20

By 7/31/20, all staff involved in completing assessments shall be re-educated regarding the requirement that a resident shall have a written initial assessment, including all resident medical diagnoses, within 15 days of admission. Documentation of education shall be submitted to the Department. SE 7/15/20

By 7/31/20, the administrator or designated staff person shall audit all resident records to ensure a current assessment is completed, accurate, to include all resident medical diagnoses, and present in each resident s record. Documentation of the audit shall be submitted to the Department.

SE 7/15/20

Legal Entity Representative Resident #4 no longer resides in the home.

SE 10/8/20

Signature Darlene Kelly Printed Name and Title DARLENE KELLY ADMINISTRATOR Date 4/24/20

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

The above plan of correction is approved as of 7/15/20 (Date)

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

Plan of correction implementation status as of 10/8/20 (Date)

✓ Implemented

Not Implemented

225c - Additional Assessment

Regulations

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's annual medical evaluation, dated 1/21/20, indicates the following diagnoses: cerebrovascular disease, chronic kidney disease stage 3, chronic c-diff, fatigue, hypertension, hyperlipidemia, coronary artery disease and edema; however, his annual assessment, dated 1/27/20, does not address these diagnoses.

Repeat Violation: 4/3/19

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.)

Supervisor will in future include all diagnoses from DME in the RAS Raise. Staff will use the DME when completing the assessment to ensure all the diagnoses are listed.

By 7/31/20, the home shall submit to the Department an updated assessment for resident #3 which accurately reflects the resident s medical diagnoses.

SE 7/15/20

By 7/31/20, all staff involved in completing assessments shall be re-educated regarding the requirement that a resident shall have a written initial assessment, including all resident medical diagnoses, within 15 days of admission. Documentation of education shall be submitted to the Department.

SE 7/15/20

By 7/31/20, the administrator or designated staff person shall audit all resident records to ensure a current assessment is completed, accurate, to include all resident medical diagnoses, and present in each resident s record. Documentation of the audit shall be submitted to the Department.

Legal Entity Representative

SE 7/15/20

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