

Department of Human Services
Bureau of Human Service Licensing

November 13, 2020

KELLY WALDMAN, MANAGING MEMBER
MAGNOLIA PLACE MANAGEMENT LLC
1326 FREEPORT ROAD, SUITE 100
PITTSBURGH, PA 15238

RE: MAGNOLIA PLACE OF SAXONBURG
100 BELLA COURT
SAXONBURG, PA, 16056
LICENSE/COC#: 45090

Dear Ms. Waldman,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/05/2020, 10/06/2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Jon Kimberland

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY**

Facility Information

Name: *MAGNOLIA PLACE OF SAXONBURG* License #: *45090* License Expiration Date: *02/20/2021*
 Address: *100 BELLA COURT, SAXONBURG, PA 16056*
 County: *BUTLER* Region: *WESTERN*

Administrator

Name: *Christal Ostrowski* Phone: *7243522827* Email: *costrowski@magnoliaplaceofsaxonburg.com*

Legal Entity

Name: *MAGNOLIA PLACE MANAGEMENT LLC*
 Address: *1326 FREEPORT ROAD, SUITE 100, PITTSBURGH, PA, 15238*
 Phone: *7243522827* Email: *KWALDMAN@WALDMANINC.COM*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *11/19/1997* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *82* Waking Staff: *62*

Inspection

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *10/06/2020*

Inspection Dates and Department Representative

10/05/2020 - On-Site: Karen Georgoulis, Belinda Graziano
10/06/2020 - On-Site: Karen Georgoulis, Beli

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* Residents Served: *61*

Secured Dementia Care Unit

In Home: *Yes* Area: *Lower Level* Capacity: *20* Residents Served: *17*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *61*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *2*
 Have Mobility Need: *21* Have Physical Disability: *4*

Inspections / Reviews

10/05/2020 - Full

Lead Inspector: *Karen Georgoulis*Follow-Up Type: *POC Submission*Follow-Up Date: *11/12/2020*

11/12/2020 - POC Submission

Lead Reviewer: *Jon Kimberland*Follow-Up Type: *Document Submission*Follow-Up Date: *11/17/2020*

11/13/2020 - Document Submission

Lead Reviewer: *Jon Kimberland*Follow-Up Type: *Not Required*

42s - Privacy

1. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 10/5/2020, there was no lock on the main door to the common shared shower room to ensure resident privacy on the second floor.

On 10/5/2020 at approximately 12:03 p.m., there was no lock on the main door to the common shared shower room to ensure resident privacy across from bedroom #401,

On 10/5/2020, at approximately 2:19 a.m., resident #1 was being showered by direct care staff person A in the common shower room of the SCDU. The main door to the common shower room was propped open to a common hallway. There were residents sitting on a bench across from the shower room. Inside the shower room, a blue privacy curtain that was drawn across the room. However, there was. Resident #1 could be seen being showered by direct care staff person A, in the small shower stall in the room from the 6" opening. Staff interviews indicated the shower room door is usually left open when showering residents for staff to be able to hear if assistance was needed by another staff.

Plan of Correction**Accept**

2600.42(s)

During the 10/5/2020 inspection the door to the shower room where staff member A was showering Resident #1 was immediately closed.

During the inspection on 10/5/2020 the Environmental Services Director immediately placed an order through a professional locksmith vendor to acquire and install master keyed locks for two (2) common shower rooms located on level two and one (1) for the common shower room located on level one within the SDCU. The SDCU Team Leader and nursing staff were immediately educated during the inspection by the Administrator, Resident Services Director and Environmental Services Director to utilize hand held communication devices, draw curtains during care services in common rooms and for all shower room doors to remain closed when in use to ensure resident privacy during care services.

On 10/22/2020 all nursing staff were educated on regulation 2600.42(s) to protect the residents' right to privacy of self and possessions and as it relates to the resident during bathing, dressing, changing and medical procedures.

On 11/2/2020 master keyed locking mechanisms were installed on level 2 and level 1 (SCDU) common shower room doors by the Environmental Services Director and locksmith.

On 11/3/2020 and 11/5/2020 the Environmental Services Director and Administrator educated all facility staff on regulation 2600.42(s) and the purpose/use of the master keyed locks on common shower rooms and use of handheld devices if assistance is needed.

Completion Date: 11/05/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/05/2020

Christal Ostrowski, ED

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/5/2020, at approximately 11:30 a.m., there were no paper towels, mechanical air blower or other means of safe hand drying available at the hand washing sink in the dining room on the second floor.

On 10/5/2020, at approximately 12:20 p.m. there was a very strong odor of urine present throughout bedroom #404, shared by resident #2 and another resident.

On 10/5/2020 at approximately 12: 23 p.m., there were no hand towels, paper towels, mechanical air blower or other means of safe hand drying available in the shared private bathroom in bedroom #404.

Plan of Correction

Accept

2600.85(a)

On 10/5/2020 during the inspection the paper towel dispenser located in the rear dining room area on level two was immediately replenished.

On 10/5/2020 during the inspection Unit #404 was cleaned immediately by housekeeping staff, hand towels replenished, personal clothing and bed linens laundered, changed emptying trash process to every shift and use of odor reducing garbage can liners for Resident #2 to address sanitary conditions related to a strong odor of urine.

To minimize the risk of illness and improve living conditions for Resident #2 residing in unit #404 and as noted on the resident support plan - laundering of personal clothes and bedding were changed to a daily processes, emptying trash every shift and as needed with incontinence episodes and care, utilization of odor reducing trash liners and housekeeping increased to twice weekly. Documentation will be kept.

Nursing staff was educated on regulation 2600.85(a) by the Resident Services Director and Administrator on 10/22/2020.

Flush mounted M/F C/F towel dispensers were ordered for level 2 rooms on 11/4/2020 and will be installed by the Environmental Services Director in resident bathrooms located at or near each bathroom sink upon delivery and/or by 11/30/2020.

Housekeeping staff will audit paper towel dispenser replenishment needs in dining and common areas daily. Documentation will be kept.

On 11/3/2020 and 11/5/2020 all facility staff was educated by the Resident Services Director, Administrator and Environmental Services Director on regulation 2600.85(a) "sanitary conditions", location of supply inventory and how to replenish paper towel dispenser supplies or other means of safe hand drying available when needed.

Completion Date: 11/30/2020

Document Submission

Implemented

See attached documentation.

Completed 11/05/2020

Christal Ostrowski, ED

85d - Trash Receptacles

1. Requirements

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 10/5/2020 at approximately 11:30 a.m. the tan trash can with the dome lid was missing the flap that covered the opening on the lid in the dining room. The trash can was approximately ½ full of trash.

Plan of Correction

Accept

2600.85(d)

On 10/5/2020 during the inspection the Environmental Services Director immediately removed the dining room trash receptacle in disrepair and placed said equipment in the dumpster.

Facility staff was educated on 11/3/2020 and 11/5/2020 by the Environmental Services Director and Administrator on regulation 2600.85(d).

New trash receptacles were ordered for the dining rooms on 11/6/2020 by the Director of Quality Assurance.

On 11/9/2020 the Environmental Services Director examined trash receptacles in kitchens and bathrooms throughout the facility to determine if lids were in place.

Housekeeping staff will audit trash receptacles throughout the facility on a weekly basis for long-term compliance. Documentation will be maintained.

Completion Date: 11/09/2020

Document Submission

Implemented

See attached documentation.

Completed 11/09/2020

Christal Ostrowski, ED

88a - Surfaces

1. Requirements

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 10/5/2020, the emergency exit door in the first-floor stairwell to the second floor, that opens to the exterior of the home has a strip of wood across the threshold with a lip of approximately 1 ½", posing a tripping hazard.

88a - Surfaces (continued)

Plan of Correction**Accept**

2600.88(a)

On 10/6/2020 the first floor stairwell emergency exit door threshold was repaired by the Environmental Services Director for immediate compliance. Repair required attachment of the aluminum ramp to the threshold.

The Environmental Services Director will examine all external doorway thresholds to determine if surfaces are clean, in good repair and free of hazards for long-term compliance. Documentation will be maintained in the building management platform TELS.

Completion Date: 10/06/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/06/2020

Christal Ostrowski, ED

101j7 - Lighting/Operable Lamp

1. Requirements

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

On 10/5/2020, at approximately 12:13 p.m., there was no source of light that can be turned on/off from the bedside of resident #3 in bedroom #303.

Plan of Correction**Accept**

2600.101(j)(7)

On 10/5/2020 an operable lamp was secured and placed at the bedside of Resident #3 in Room #303 for immediate compliance by the Environmental Services Director with the Licensing Representative present.

The Environmental Services Director audited facility wide compliance related to resident rooms having a source of lighting present with either an operable lamp or other source of lighting located at bedside, verified ease of turning on/off and providing sufficient light to reduce the risk of falls and injury.

Facility staff educated on regulation 2600.101(j) on 11/5/2020.

Housekeeping staff and/or other Designee will audit rooms weekly for long-term compliance. Documentation will be kept.

Completion Date: 11/09/2020

101j7 - Lighting/Operable Lamp *(continued)***Document Submission****Implemented***See attached documentation.**Completed 11/09/2020**Christal Ostrowski, ED*

103e - Left Overs

1. Requirements

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

On 10/5/2020, there was an unlabeled, undated, 2lb package of Cobble Street Market turkey slices in Cooler #2 on the right side in the basement pantry.

Plan of Correction**Accept***2600.103(e)*

During the inspection on 10/5/2020 the Director of Quality Assurance immediately disposed of the 2lb package of unlabeled and undated turkey slices in Cooler #2 while the Licensing Representative was present.

During the inspection the Director of Quality Assurance immediately reviewed food storage practices, procedures and regulatory compliance requirements with the kitchen and dining staff.

On 11/5/2020 facility staff was educated by the Administrator and Director of Quality Assurance on regulation 2600.103(e), food safety procedures and daily observation of leftovers in storage to prevent cross-contamination of food and the use of expired food items. The Director of Quality Assurance and/or Designee will audit and maintain documentation of food storage areas daily.

Dining and kitchen will be trained at time of hire and annually on specific job functions as it related to their position. Documentation will be kept in the facility learning platform Relias.

Completion Date: *11/09/2020*

Document Submission**Implemented***See attached documentation.**Completed 11/09/2020**Christal Ostrowski, ED*

103g - Storing Food

1. Requirements

2600.

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

103g - Storing Food (continued)

Description of Violation

On 10/5/2020, there was an open, unsealed bag of bread with approximately 6 slices remaining in the bag on the first shelf of the top cabinet on the right side of the microwave.

On 10/5/2020, there was an open, unsealed 2lb package of Cobble Street Market turkey slices on the right side of Cooler #2 in the basement pantry.

Plan of Correction

Accept

2600.103(g)

On 10/5/2020 during the inspection of the SDCU kitchenette a bag of bread with a twist tie mechanism was not completely fastened. The improperly stored food item was immediately disposed of during the inspection.

During the inspection the Administrator and Director of Quality Assurance immediately reviewed food storage practices, procedures and regulatory compliance requirements with kitchen and dining staff.

Facility staff was educated by the Administrator and Director of Quality Assurance 11/5/2020 on regulation 2600.103(g) and regulation 2600.103(e), food safety procedures and daily observation of food storage areas to ensure food is stored safely and protected. The Director of Quality Assurance and/or Designee will audit and maintain documentation of food storage areas daily.

Dining and kitchen staff will be trained at time of hire and annually on specific job functions as it relates to their position. Documentation will be kept in the facility learning platform Relias.

Completion Date: 11/09/2020

Document Submission

Implemented

See attached documentation.

Completed 11/09/2020

Christal Ostrowski, ED

133.1 - Exit Signs

1. Requirements

2600.

133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

On 10/5/2020, there was no exit sign above the doorway of the main front exit of the home.

133.1 - Exit Signs *(continued)***Plan of Correction****Accept**

2600.133(1)

On 10/5/2020 during the inspection the Environmental Services Director immediately affixed a sign bearing the word "EXIT" in plain legible letters over the doorway of the main front entrance/exit of the home.

Fire Fighter Sales and Service was contacted by the Environmental Services Director during the inspection to obtain a quote for the installation of one (1) emergency/exit light combination unit for long-term compliance.

10/16/2020 quote for permanent addition of emergency/exit light unit executed by Administrator.

10/21/2020 emergency/exit light combo unit installed by Fire Fighter Sales and Services.

Facility staff educated by the Environmental Services Director 11/5/2020 on regulation 2600.133(1).

The Environmental Services Director will check functionality of the emergency/exit light weekly and battery backup monthly and document in the building management platform TELS.

Completion Date: 11/05/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/05/2020

Christal Ostrowski, ED

184b - Resident's Meds Labeled

1. Requirements

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

The following OTC medications prescribed for resident #4 were not labeled with the resident's name or initials, to include:

- Turmeric - take two tablets by mouth daily (8:00 a.m.)*
- Vitamin D-3 -take one tablet by mouth daily (8:00 a.m.)*

184b - Resident's Meds Labeled (*continued*)**Plan of Correction****Accept**

2600.184(b)

During the inspection on 10/5/2020 the Resident Services Director immediately removed the OTC medications prescribed for Resident #4 and labeled the Tumeric and Vitamin D-3 with the name of Resident #4.

On 10/9/2020 the Resident Services Director and Support Nurse Supervisor conducted a whole house medication cart audit to assess regulatory compliance with 2600.184(b) Labeling of Medications. The Resident Services Director, Support Nurse Supervisor and/or Designee will conduct medication cart audits every other week for a period of three months to assure OTC medications are labeled with the resident's name. Documentation will be kept on file.

Medication Technicians were educated on 10/22/2020 by the Resident Services Director on the purpose and procedure for labeling of OTC medications. The Resident Services Director and Support Nurse Supervisor educated nursing staff on 11/5/2020 and 11/6/2020 on the regulation, facility policy and procedures associated with 2600.184(a)-(c) Labeling of Medications.

Completion Date: 11/09/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/09/2020

Christal Ostrowski, ED

185a - Implement Storage Procedures

1. Requirements

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 10/5/2020, resident #5 is prescribed Trazadone, 50 mg – take one and a half tablet (75mg) at bedtime. There were two punch cards of medication in the med cart, each packaged with 45 individual doses of one and one-half tablets, numbered 1 – 45. However, the second card was incorrectly packaged with dose #10 having only one whole tablet and dose #11 having one whole tablet and two ½ tablets. The home did not follow their medication policy for Receipt of Non-Controlled Meds, as follows:

- 1. The medications are delivered from the pharmacy on either an as needed basis or on a cycle determined by the pharmacy. The medications are immediately verified and secured at the time of delivery.*
- 2. Upon receipt of non-controlled medications by the staff member responsible for administering medications, the delivery invoice is signed by the delivery person and staff member receiving the medication indicating accuracy and accountability of medications received.*

185a - Implement Storage Procedures (*continued*)**Plan of Correction****Accept**

2600.185(a)

During the inspection on 10/5/2020 the Resident Services Director immediately pulled the medication blister pack from the med cart and notified the pharmacy of the packaging error. A new card of correctly packaged medication was received and verified for Resident #5 on 10/5/2020.

On 10/9/2020 the Resident Services Director and Support Nurse Supervisor conducted a whole house medication cart audit to assess compliance with procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff. The Resident Services Director, Support Nurse Supervisor and/or Designee will conduct medication cart audits every other week for a period of three months. Pharmacy audits will be conducted quarterly. Documentation will be kept on file.

Medication Technicians were educated on 10/22/2020 by the Resident Services Director on the purpose and procedure for receiving non-controlled and controlled medications, verification and securing medications at time of delivery.. The Resident Services Director and Support Nurse Supervisor educated nursing staff on 11/5/2020 and 11/6/2020 on the the Accountability of Medication and Controlled Substances, and facility policy and procedures related to regulation 2600.185(a-b).

Completion Date: 11/09/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/09/2020

Christal Ostrowski, ED

187b - Date/Time of Medication Admin.

1. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #5 is prescribed Lorazepam 0.5mg tablet, take one-half tablet (0.25mg) by mouth three times daily (10:00 a.m.; 3:00 p.m. and 9:00 p.m.) The resident's October 2020 Medication Administration Record (MAR) was not initialed by the staff person who administered the medication on 10/1/2020 at 3:00 p.m.

187b - Date/Time of Medication Admin. (continued)

Plan of Correction**Accept**

2600.187(b)

The Staff Member on duty who administered Resident #5 the prescribed medication on 10/1/2020 at 3:00 p.m. and omitted initials on the residents October 2020 Medication Administration Record (MAR) at time of medication administration was reeducated via verbal coaching with the Resident Services Director and a late entry was documented in the MAR after verification.

On 10/22/2020 the Resident Services Director educated Medication Technicians on the purpose and procedure for medication records and recording medications at the time the medication is administered to assure residents receive all medications and are administered as prescribed.

On 11/5/2020 and 11/6/2020 the Resident Services Director and Support Nurse Supervisor educated Medication Technicians on regulation 2600.187(a-d) and facility policy and procedures as related to Medication Records.

To measure compliance Medication Administration Records will be audited weekly for four weeks then monthly thereafter. Documentation will be kept.

Completion Date: 11/09/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/09/2020

Christal Ostrowski, ED

224a - Preadmission Screen Form

1. Requirements

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

Resident #5, admitted 9/2/2020, preadmission screening, dated 9/2/2020, does not indicate the home can meet the resident's needs. This area is blank.

224a - Preadmission Screen Form (*continued*)**Plan of Correction****Accept**

2600.224(a)

At the time of the inspection on 10/5/2020 the Resident Services Director immediately corrected the preadmission screening for Resident #5 by indicating with a check mark that the needs of the resident can be met by the services provided by the home.

The Support Nurse Supervisor conducted a whole house audit of preadmission screening forms to measure compliance. The Resident Services Director and/or Designee will review each preadmission screening form for accuracy to assure the facility can safely meet a resident's needs prior to admission. Pre-admission screens will be tracked on an audit tool for long-term compliance. Documentation will be kept.

On 11/6/2020 the Administrator reviewed the facility policy and procedure related to Preadmission Screening and educated the Resident Services Director and Support Nurse Supervisor on regulatory requirements of 2600.224(a) and Preadmission Screening, Medical Evaluation, and Assessment-Support Plan Best Practices.

Completion Date: 11/06/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/06/2020

Christal Ostrowski, ED

225a - Assessment 15 Days

1. Requirements

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 admitted 4/8/2020, assessment does not indicate the date the assessment was finalized. The section is blank.

Resident #5 admitted 9/2/2020, assessment does not indicate the date the assessment was finalized. The section is blank.

Resident #6 admitted 2/20/2020, assessment does not indicate the date the assessment was finalized. The section is blank.

Resident #7 admitted 2/20/2020, assessment does not indicate the date the assessment was finalized. The section is blank.

225a - Assessment 15 Days *(continued)***Plan of Correction****Accept**

2600.225(a)

On 10/5/2020 during the inspection the Resident Services Director immediately corrected the assessment records of Resident #4, Resident #5, Resident #6 and Resident #7 by indicating the date the assessment was finalized.

The Support Nurse Supervisor conducted a whole house audit of resident assessments to measure compliance. The Resident Services Director and/or Designee will monitor resident assessments via audit tool on an ongoing basis to measure compliance with the regulation and assure each residents written initial assessment is dated the day of assessment finalization. Documentation will be kept.

On 11/6/2020 the Administrator reviewed the facility policy and procedure related to Initial and Annual Assessments and educated the Resident Services Director and Support Nurse Supervisor on regulatory requirements of 2600.225(a)(c)(d) Initial and Annual Assessment (and Development of the Support Plan) and regulatory Best Practices.

Completion Date: 11/06/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/06/2020

Christal Ostrowski, ED

227a - Support Plan 30 Days

1. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #4 admitted 4/8/2020, support plan does not indicate the date the support plan was finalized. The section is blank.

Resident #5 admitted 9/2/2020, support plan does not indicate the date the support plan was finalized. The section is blank.

Resident #6 admitted 2/20/2020, support plan does not indicate the date the support plan was finalized. The section is blank.

Resident #7 admitted 2/20/2020, support plan does not indicate the date the support plan was finalized. The section is blank.

227a - Support Plan 30 Days (*continued*)**Plan of Correction****Accept**

2600.227(a)

On 10/5/2020 during the inspection the Resident Services Director immediately corrected the support plan records of Resident #4, Resident #5, Resident #6 and Resident #7 by indicating the date the support plan was finalized.

The Support Nurse Supervisor conducted a whole house audit of resident support plans to measure compliance. The Resident Services Director and/or Designee will monitor resident support plans via audit tool on an ongoing basis to measure compliance with the regulation and assure each residents written support plan is dated the day of support plan completion. Documentation will be kept.

On 11/6/2020 the Administrator reviewed the facility policy and procedure related to Development of the Support Plan (and Assessments) and educated the Resident Services Director and Support Nurse Supervisor on regulatory requirements of 2600.227 Development of the Support Plan and regulatory Best Practices.

Completion Date: 11/06/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/06/2020

Christal Ostrowski, ED

231e - No Objection Statement

1. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #8 was admitted to the Secure Dementia Care Unit (SCDU) on 2/20/2020. The home has no documentation that the resident or resident's designated person has not objected to the admission.

231e - No Objection Statement (*continued*)**Plan of Correction****Accept**

2600.231(e)

On 10/5/2020 the Admissions and Marketing Director immediately contacted Resident #8 Responsible Party via telephone and emailed the document to obtain the designated person signature on the new entity SDCU acknowledgement and consent form for Resident #8 to reside in a SDCU. At time of legal entity change on 2/20/2020 Resident #8 initialed the new entity consent and Responsible Party was contacted while residing out of state during the pandemic in attempt to secure documentation on the new entity form. Documentation has not been returned by the responsible party. Previous legal entity documents with both resident and designated person signature are on file. On 10/13/2020 the Admissions and Marketing Director mailed communication regarding continued need for Responsible Party signature on the consent form and included a postage paid return envelope. On 11/6/2020 the Admissions and Marketing Director followed up with an additional communication regarding documentation requirement on the new entity form. Mail was sent to the Responsible Party via the USPS with Certified Mail Receipt on file.

The Admissions and Marketing Director audited SDCU resident admission records from time of legal entity change on 2/20/20 through 10/13/2020. The Admissions and Marketing Director and/or Designee will continue utilization of the audit tool to meet regulatory compliance related to regulation 2600.231(e) to ensure residents and their designated persons have chosen a secured setting. Documentation will be kept on file.

On 11/6/2020 the Administrator educated the Director of Admissions and Marketing, Resident Services Director, Support Nurse Supervisor and SDCU Team Leader on regulatory requirements of 2600.231(e).

Completion Date: 11/06/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/06/2020

Christal Ostrowski, ED

234a - Admission Support Plan

1. Requirements

2600.

- 234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #8 admitted to the SDCU 2/20/2020. However, the resident's initial support plan was not dated, therefore, unable to determine if the support plan was completed within 72 hours of admission, or within 72 hours prior to the admission.

Resident #9 admitted to the SDCU 6/18/2020. However, the resident's support plan is not dated, therefore, unable to determine if the support plan was completed within 72 hours of admission, or within 72 hours prior to the admission.

234a - Admission Support Plan (*continued*)**Plan of Correction****Accept**

2600.234(a)

On 10/5/2020 during the inspection the Resident Services Director immediately corrected the initial admission support plan records of Resident #8 and Resident #9 admission to the SCDU by indicating the date the support plan was finalized.

The Support Nurse Supervisor conducted a whole house audit of resident support plans to measure compliance. The Resident Services Director and/or Designee will monitor SDCU resident admission support plans via audit tool on an ongoing basis to measure compliance with regulation requirements and assure each residents SCDU admission support plan is dated the day of support plan completion. Documentation will be kept.

On 11/6/2020 the Administrator provided education to the Resident Services Director and Support Nurse Supervisor on regulation 2600.234(a) and Assessment-Support Plan Best Practices as provided in "Regulatory Issues and Frequently-Occurring Situations".

Completion Date: 11/06/2020

Document Submission**Implemented**

See attached documentation.

Completed 11/06/2020

Christal Ostrowski, ED