Department of Human Services
Bureau of Human Service Licensing

February 1, 2021

SHAWN BRANDT, EXECUTIVE DIRECTOR
CARE HSL HARLEYSVILLE OPCO LLC
765 SKIPPACK PIKE
HERITAGE SENIOR LIVING
BLUEBELL, PA 19422

RE: BIRCHES AT ARBOUR SQUARE
691 MAIN STREET
HARLEYSVILLE, PA, 19438
LICENSE/COC#: 14266

Dear Ms. Brandt,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/19/2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Claire Mendez

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: *BIRCHES AT ARBOUR SQUARE* **License #**: *14266* **License Expiration Date**: *03/27/2021*
Address: *691 MAIN STREET, HARLEYSVILLE, PA 19438*
County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: *Shawn Brandt* **Phone**: *2155413700* **Email**: *sbrandt@chestnutknoll.com*

Legal Entity

Name: *CARE HSL HARLEYSVILLE OPCO LLC*
Address: *765 SKIPPACK PIKE, HERITAGE SENIOR LIVING, BLUEBELL, PA, 19422*
Phone: *2155413700* **Email**: *MHAYDEN@HERITAGESL.COM*

Certificate(s) of Occupancy

Type: *R-3* **Date**: *03/10/2009* **Issued By**: *Lower Salford Tonwship*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *92* **Waking Staff**: *69*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *11/19/2020*

Inspection Dates and Department Representative

11/19/2020 - On-Site: Denise Siniari, Youn Hie Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *61*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *25* **Residents Served**: *22*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *61*
Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

11/19/2020 - Full

Lead Inspector: *Denise Siniari* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/31/2020*

Inspections / Reviews *(continued)*

1/4/2021 - POC Submission

Lead Reviewer: *Claire Mendez* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/30/2021*

2/1/2021 - Document Submission

Lead Reviewer: *Claire Mendez* **Follow-Up Type**: *Not Required*

51 - Criminal Background Check

1. Requirements

2600.

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

Description of Violation

Staff Member A hired as a medication technician on 6/16/17. The home did not complete the criminal background check for Staff Member A until 4/18/19.

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a Team Member was hired 6/16/17. The home didn't complete the criminal background check until 4/18/19.
Who: The Executive Director (ED) or designee will train the Management and Business Office Department team on Plan of Correction-Criminal Background Check (Attachment A) and Business Office Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment C).
When: Training to be completed by 1/29/20
How: Business Office Director or Designee will assure all criminal background checks are completed in accordance with the departments hiring process.
Ongoing: The Business Office Director or Designee will conduct a weekly audit of all new hires and the completion of their background check will be completed and documented on Business Office Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person B, whose first day of work was 7/26/18, did not receive orientation.

Repeat Violation 9/18/19

65a - FS Orientation 1st Day *(continued)*

Plan of Correction **Accept**

What: A Team member, whose first day of work was 7/26/18, did not receive orientation in general fire safety and emergency preparedness. The orientation was completed for this team member on 12/31/20.
Who: The Executive Director (ED) or designee will train the Management and Business Office Department team on Plan of Correction- 1st Day Orientation Fire Safety/Emergency Preparedness (Attachment D) and Business Office Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment E).
When: Training to be completed by 1/29/20
How: Business Office Director or Designee will assure all first day orientation for fire safety and emergency preparedness are completed.
Ongoing: The Business Office Director or Designee will conduct a weekly audit of all new hires and the completion of their first day orientation for fire safety and emergency preparedness will be completed and documented on Business Office Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

65b - Rights/Abuse 40 Hours

1. **Requirements**

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person B completed his/her 40th scheduled work hour on 8/2/2018. However, this staff person did not complete training.

Repeat Violation 9/18/19

65b - Rights/Abuse 40 Hours *(continued)*

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a team member didn't receive new hire orientation for resident's rights, emergency medical plan, abuse and neglect reporting, and reporting of reportable incidents/conditions within 40 scheduled working hours. The orientation was completed for this team member on 12/31/20.
Who: The Executive Director (ED) or designee will train the Management and Business Office Department team on Plan of Correction-New Hire Orientation Within 40 scheduled hours of Hire (Attachment F) and Business Office Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment G).
When: Training to be completed by 1/29/20
How: Business Office Director or Designee will assure all new team members new hire orientation for resident's rights, emergency medical plan, abuse and neglect reporting, and reporting of reportable incidents/conditions within 40 scheduled working hours are completed.
Ongoing: The Business Office Director or Designee will conduct a weekly audit of all new hires and the completion of their orientation for resident's rights, emergency medical plan, abuse and neglect reporting, and reporting of reportable incidents/conditions within 40 scheduled working hours are completed and documented on Business Office Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

65g - Annual Training Content

1. **Requirements**

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.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff Person B did not receive training in fire safety, emergency preparedness, resident rights, the older adult protective services act, falls and accident protection during training year January 1, 2019 to December 31, 2019.

65g - Annual Training Content *(continued)*

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a team member didn't receive annual training in fire safety, emergency preparedness, resident rights, the older adult protective services act, fall and accident prevention during the training year 1/1/19 through 12/31/19. The annual training was completed for this team member on 12/31/20.
Who: The Executive Director (ED) or designee will train the Management and Business Office Department team on Plan of Correction-Annual Training Content Areas (Attachment H) and Business Office Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment I).
When: Training to be completed by 1/29/20
How: Department Directors or Designee will assure all team members annual training assignment for the month are completed.
Ongoing: The Business Office Director or Designee will conduct a weekly audit of all team members annual training assignment for the month are not completed and document on Business Office Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

82c - Locking Poisonous Materials

1. **Requirements**

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

Crest toothpaste, with a manufacture's label indicating "if more than used for brushing is swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in Bedroom 23. Bedroom 23 is located in the secured dementia care unit. Not all the residents of the home, including Resident # 1, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction **Accept**

What: On 11/19/20, it was identified that Crest toothpaste, with a manufacture's label indicating "if more than used for brushing is swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in a resident's bedroom located in Daybreak. Not all of the residents in Daybreak have been assessed capable of recognizing and using poisons safely. This was corrected at the time it was identified on 11/19/20.
Who: The Maintenance Director or designee will train All Members on Plan of Correction-Poisonous Materials (Attachment J) and Weekly Environment Audit Tool (Attachment K) and complete Sign-in Sheet (Attachment L).
When: Training to be completed by 1/29/20
How: All Team Members will assure items with a manufacture's label indicating "if more than used for brushing is swallowed, get medical help or contact a Poison Control Center right away", are locked and not accessible to residents in Daybreak.
Ongoing: The Maintenance Director or Designee will conduct a weekly audit of a resident's room in Daybreak for poisonous materials document on Weekly Environment Audit Tool (Attachment K). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

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

The home had stained ceiling tiles right inside the door of Daybreak.

Plan of Correction **Accept**

What: On 11/19/20, it was identified that there was a stained ceiling tiles right inside the door of Daybreak. This was corrected when the tiles were painted on 12/29/20.
Who: The Maintenance Director or designee will train the Managers, Housekeeping, and Maintenance Departments on Plan of Correction-Environmental Conditions of Surfaces (Attachment M) and Weekly Environment Audit Tool (Attachment K) and complete Sign-in Sheet (Attachment O).
When: Training to be completed by 1/29/20
How: The Managers, Housekeeping, and Maintenance Departments will assure Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards in Daybreak.
Ongoing: The Maintenance Director or Designee will conduct a weekly audit in Daybreak for surfaces to be clean, in good repair and free of hazards while documenting on Weekly Environment Audit Tool (Attachment K). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

141a 1-10 Medical Evaluation Information

1. Requirements

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 resident's medical evaluation did not include Resident # 2's medication list.

The resident's medical evaluation did not include Resident # 3's medication list.

Plan of Correction **Accept**

What: On 11/19/20, it was identified that there were 2 residents with medication lists missing from their medical evaluation. This was unable to correct but will be when the next DME is due.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-DME Missed Medication List (Attachment P), DME Page 3 (Attachment Q) and Weekly Clinical Audit Tool (Attachment R) and complete Sign-in Sheet (Attachment S).
When: Training to be completed by 1/29/20
How: The Med Techs and Clinical Leadership team will assure DME Page 3 (Attachment Q) is filled out with every medical evaluation.
Ongoing: The Resident Care Director or Designee will conduct a weekly of all new medical evaluations completed that week have medication lists and document on Weekly Clinical Audit Tool (Attachment R). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

141b1 - Annual Medical Evaluation

1. Requirements

2600.

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

Description of Violation

Resident #3's most recent medical evaluation was completed on 11/19/19. The resident's previous medical evaluation was completed on 10/23/18.

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a residents most recent medical evaluation was completed on 11/19/19. The resident's previous medical evaluation was completed on 10/23/19. This was attempted to be corrected on 9/23/20 when a new medical evaluation was completed but it didn't have a medication list. It will be corrected when a new annual DME is completed.
Who: The Resident Care Director (RCD) or designee will train the Clinical Leadership team on Plan of Correction-Annual DME requirement (Attachment T) and Weekly Clinical Audit Tool (Attachment R) and complete Sign-in Sheet (Attachment U).
When: Training to be completed by 1/29/20
How: The Clinical Leadership team will assure a new medical evaluation is completed at least annually.
Ongoing: The Resident Care Director or Designee will conduct a weekly audit of all medical evaluations due that week requiring a new annual evaluation and document on Weekly Clinical Audit Tool (Attachment R). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

182c - Medication Administration

1. **Requirements**

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.

Description of Violation

Resident # 4 was prescribed Lorazepam 1mg tablet by mouth every evening. On 11/14/ 2020 at 4:22 P.M. Resident # 4 was administered 0.5 mg of Lorazepam. On 11/15/2020 at 5:00 P.M. Resident # 4 was administered 0.5 mg of Lorazepam.

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a resident was prescribed Lorazepam 1mg tablet by mouth every evening. On 11/15/20 at 5:00 PM that resident was administered .5 mg of Lorazepam. It was corrected when the resident received the next administered dose.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Medication Administration (Attachment V) and Cart Audit and Med Cart Education Tool (Attachment W) and complete Sign-in Sheet (Attachment X).
When: Training to be completed by 1/29/20
How: The Med Techs and Clinical Leadership team will assure prescriber's orders match what residents are administered.
Ongoing: The Resident Care Director or Designee will conduct a weekly cart audit to check that orders match what is administered to residents and document on Cart Audit (Attachment W). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

182c - Medication Administration *(continued)*

Document Submission **Implemented**

See attached training documentation

183d - Prescription Current

1. **Requirements**

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

On 9/10/2020, Vitamin D 3 50,000 IU capsules were prescribed for Resident # 5, was in the home's 1 floor short hall medication cart; however, the medication was discontinued on 10/22/2020.

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a resident on 9/10/20 was prescribed Vitamin D # 50,000 IU capsules. The medication was discontinued on 10/22/20 and still in the med cart on the first-floor short hall. This was corrected on 11/19/20 when the capsules were removed and destroyed.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Disposal of Discontinued Medications (Attachment Y) and Cart Audit and Med Cart Education Tool (Attachment W) and complete Sign-in Sheet (Attachment Z).
When: Training to be completed by 1/29/20
How: The Clinical Leadership team will assure only current prescriptions for individuals living in the home are kept in the home.
Ongoing: The Resident Care Director or Designee will conduct a weekly cart audit to check that only current prescriptions for individuals living in the home are kept in the home and document on Cart Audit (Attachment W). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

183e - Storing Medications

1. **Requirements**

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 11/19/2020 Resident # 6's Humalog kwikipen with an open date of 9/29/2020 was present on the 2nd floor medication cart. According to the manufacturer's instructions, this medication should be discarded 28 days after it is opened.

183e - Storing Medications *(continued)*

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a residents Humalog kwikipen with an open date of 9/29/20 was present on the 2nd floor medication cart. According to the manufacture's instructions, this medication should be discarded 28 days after it is opened. This was corrected on 11/19/20 when the Humalog was removed and destroyed.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Medication Storage (Attachment AA) and Cart Audit and Med Cart Education Tool (Attachment W) and complete Sign-in Sheet (Attachment BB)
When: Training to be completed by 1/29/20
How: The Med Techs and Clinical Leadership team will assure prescription medications; OTC medications and CAM shall be stored in accordance with the manufacturer's instructions.
Ongoing: The Resident Care Director or Designee will conduct a weekly cart audit to check that only prescription medications, OTC medications and CAM shall be stored in accordance with the manufacturer's instructions and document on Cart Audit (Attachment W). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

187a - Medication Record

1. **Requirements**

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident # 7 is prescribed Lorazepam 0.5 mg 1 tablet twice daily. This medication was administered three times on 11/14/2020; however the third administration is not included on Resident #7's medication administration record.

187a - Medication Record *(continued)*

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a resident was prescribed Lorazepam .5 mg 1 tablet twice daily. This medication was administered 3 times on 11/14/20; However, the third administration is not included on the MAR. This was corrected when the Med Tech who gave the extra dose was educated on the rights of medication administration and the resident received the next prescribed administration of Lorazepam appropriately.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Medication Administration Recorded on the MAR (Attachment CC) and Weekly Clinical Audit Tool (Attachment R) and complete Sign-in Sheet (Attachment DD).
When: Training to be completed by 1/29/20
How: The Med Techs and Clinical Leadership team will assure only medications prescribed are given to residents and not to give extra doses.
Ongoing: The Resident Care Director or Designee will conduct a random weekly audit of 3 residents administration history (admin hx) in our EMAR System (Quickmar) to check that only prescribed medications are administered to residents and document on Weekly Clinical Audit Tool (Attachment R). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

187d - Follow Prescriber's Orders

1. **Requirements**

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

Description of Violation

Resident # 4 is prescribed Lorazepam 1mg 1 tablet once daily in the evening. However, 11/14/2020 at 4:22 P.M. and at 11/15/2020 at 5:00 P.M., Resident #4 was administered Lorazepam 0.5 mg 1 tablet

Resident # 7 was prescribed Lorazepam 0.5 mg twice daily. However, on 11/14/2020 this medication was administered three times: at 7:51 A.M., 3:30 P.M., and 5:00 P.M.

Repeat Violation 11/4/19

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a resident was prescribed Lorazepam 1mg 1 tablet once daily in the evening. However, on 11/14/20 and 11/15/20 the resident received one Lorazepam 0.5mg tablet. This was corrected when the Med Tech who gave the extra dose was educated on the 5 rights of medication administration and the resident received the next prescribed administration of Lorazepam appropriately.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Follow Direction of Prescriber's Orders (Attachment EE) and Cart Audit and Med Cart Education Tool (Attachment W) and complete Sign-in Sheet (Attachment FF).
When: Training to be completed by 1/29/20
How: The Med Techs and Clinical Leadership team will assure correct medication doses prescribed are given to residents.
Ongoing: The Resident Care Director or Designee will conduct a weekly cart audit to check that correct medication doses prescribed are given to residents and document on Cart Audit (Attachment W). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

188b - Medication Error Reporting

1. **Requirements**

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident # 7 is prescribed Lorazepam 0.5 mg 1 tablet twice daily. However, Resident #7 was administered Lorazepam 0.5 mg 1 tablet three times on 11/14/20 at 7:51 A.M., 3:30P.M., and 5:00P.M.. Staff Member C administered the medication at 5:00 P.M. and recorded it on the narcotic count log but was unable to record it on Resident # 7's medication administration record. The medication error was not reported to the Department.

188b - Medication Error Reporting *(continued)*

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a resident was prescribed Lorazepam .05mg 1 tablet twice daily. However, the resident received one 0.5mg tablet 3 times a day on 11/14/20. The medication error was never reported to the department. This was corrected when the medication error was reported on 12/31/20 and the Med Tech who gave the extra dose was educated on the rights of medication administration.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Medication Error Reporting (Attachment GG) and Weekly Clinical Audit Tool (Attachment R) and complete Sign-in Sheet (Attachment HH).
When: Training to be completed by 1/29/20
How: The Med Techs and Clinical Leadership team will assure medication errors are timely reported to the department.
Ongoing: The Resident Care Director or Designee will conduct a random weekly audit of 3 residents MAR for med errors and document on Weekly Clinical Audit Tool (Attachment R). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

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 # 2 was admitted on 8/6/2020; however, the resident's assessment was not completed until 8/24/2020.

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a resident admitted on 8/6/20 did not have an assessment completed until 8/24/20. This will be corrected when the annual or significate change assessment is completed.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Support Plan Completion Timeframe (Attachment II) and Weekly Clinical Audit Tool (Attachment R) and complete Sign-in Sheet (Attachment JJ).
When: Training to be completed by 1/29/20
How: The Clinical Leadership team will assure a new resident assessment is completed timely after admission.
Ongoing: The Resident Care Director or Designee will conduct a random weekly audit of all residents who were admitted in the last week to make sure their assessment has been completed in 15 days for Personal Care and 72 hours for Memory Care residents and document on Weekly Clinical Audit Tool (Attachment R). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

225c - Additional Assessment

1. Requirements

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

Resident #8's current assessment was completed on 10/18/2020. However, the resident's significant change occurred on 10/9/2020.

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a current resident's assessment was completed on 10/18/20 but the significant change occurred on 10/9/20. This will be corrected when the annual or significate change assessment is completed.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Correction-Support Plan for Significant Changes (Attachment KK) and Weekly Clinical Audit Tool (Attachment R) and complete Sign-in Sheet (Attachment LL).
When: Training to be completed by 1/29/20
How: The Clinical Leadership team will assure a new resident assessment is completed timely when a resident has a significant change.
Ongoing: The Resident Care Director or Designee will conduct a random weekly audit of all residents who had a significate change that week and have a new assessment and document on Weekly Clinical Audit Tool (Attachment R). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation

227h - Support Plan Refuse Sign

1. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident # 9 participated in the development of his/her support plan on 10/16/2020. The resident was unable to sign the support plan. The home did not make a notation regarding the resident's inability to sign.

227h - Support Plan Refuse Sign *(continued)*

Plan of Correction **Accept**

What: On 11/19/20, it was identified that a resident participated in the development of their support plan on 10/16/20. The resident was unable to sign the support plan and a notation wasn't made regarding the resident's inability to sign. This was corrected when a notation was made on 12/31/20.
Who: The Resident Care Director (RCD) or designee will train the Med Techs and Clinical Leadership team on Plan of Corrector-Resident Signing the Support Plan (Attachment MM) and Weekly Clinical Audit Tool (Attachment R) and complete Sign-in Sheet (Attachment NN).
When: Training to be completed by 1/29/20
How: The Clinical Leadership team will assure when a resident is unable or chooses not to sign the support plan, a notation of inability or refusal to sign is documented.
Ongoing: The Resident Care Director or Designee will conduct a random weekly audit of 3 resident's support plans for documentation if the resident hasn't signed and document on Weekly Clinical Audit Tool (Attachment R). Findings and trends will be reviewed at the QA meetings.

Completion Date: *12/31/2020*

Document Submission **Implemented**

See attached training documentation