Department of Human Services
Bureau of Human Service Licensing

June 29, 2021

[redacted], VICE CHAIRMAN MANAGER
HAMPDEN OPERATIONS LLC
4423 PHEASANT RIDGE RD,STE 301
ROANOKE, VA 24014

RE: HARMONY AT WEST SHORE
1910 TECHNOLOGY PARKWAY
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33381

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 04/27/2021, 04/28/2021, 04/29/2021, 03/09/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Gloria Emick

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *HARMONY AT WEST SHORE* **License #:** *33381* **License Expiration Date:** *05/03/2021*
Address: *1910 TECHNOLOGY PARKWAY, MECHANICSBURG, PA 17050*
County: *CUMBERLAND* **Region:** *CENTRAL*

Administrator

Name: [redacted] **Phone:** *7174021200* **Email:** [redacted]

Legal Entity

Name: *HAMPDEN OPERATIONS LLC*
Address: *4423 PHEASANT RIDGE RD,STE 301, ROANOKE, VA, 24014*
Phone: *7174021200* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date:** *05/01/2016* **Issued By:** *Hampden Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *91* **Waking Staff:** *68*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal,Complaint* **Exit Conference Date:** *04/29/2021*

Inspection Dates and Department Representative

04/27/2021 - On-Site: [redacted]
04/28/2021 - On-Site: [redacted]
04/29/2021 - On-Site: [redacted]
03/09/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served:** *66*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Harmony Square* **Capacity:** *35* **Residents Served:** *23*

Hospice

Current Residents: *10*

Resident Demographic Data as of Inspection Dates *(continued)*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *66*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *25*
Have Physical Disability: *1*

Inspections / Reviews

04/27/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/13/2021*

6/24/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/01/2021*

6/29/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/30/2021*

16c - Written Incident Report

1. Requirements

2600.

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

Description of Violation

On 4/18/2021 and 4/26/2021, several residents did not receive their prescribed morning medications. These medication errors were not reported to the Department:
Resident #2 did not receive prescribed Carbidopa-Levo, Duloxetine HCL, Mag-Tab SR, Metformin, Metoprolol Tartrate, Novolog and Pantoprazole Sod DR at 8:00 AM on 4/18/21.
Resident #3 did not receive prescribed Carbidopa-Levodopa, Buspirone HCL, Furosemide, Metoprolol Tartrate at 8 AM on 4/18/21.
Resident #3 did not receive prescribed Potassium CL at 8:00 AM on 4/20/21 and Digoxin at 8:00 AM on 4/26/21.
Resident #4 did not receive prescribed Topiramate at 8:00 AM on 4/18/21.
Resident #5 did not receive prescribed Hydrocortisone, Levetiracetam, Sodium Chloride at 8:00 AM and Levothyroxine at 7:30 AM on 4/18/21.
Resident #6 did not receive prescribed Acetaminophen 500 mg, Breo Ellipta, Bupropion HCL, Divalproex Sod DR, Duloxetine HCL DR, Eliquis, Escitalopram, Famotidine, Fluticasone Prop, Lidocaine Patch, Magnesium Oxide, Risperidone and Topiramate at 8:00 AM on 4/18/21.
Resident #7 did not receive prescribed Carvedilol, Lorazepam and Pantoprazole Sod DR at 8:00 AM on 4/18/21.
Resident #8 did not receive prescribed Carvedilol at 8:00 AM on 4/18/21.

Medication errors that occurred when medications were not available in the facility were not reported to the Department as a reportable incident as required.

Plan of Correction **Accept**

All medication errors will be reported to the department as a reportable incident and the Healthcare Director and Executive Director will ensure proper reporting.
Healthcare Director will monitor for any medication errors through the MAR on a weekly basis per company policy and evaluate the reporting of medication errors during the Quality Management Reviews on a monthly basis.
Staff will be re-educated on the process of reporting Reportable Incidents that are required to be reported as outlined in regulation 2600.16(a) and 2600.188(a). The re-education of staff shall be completed by August 1, 2021

Completion Date: *06/25/2021*

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

25b - Contract Signatures *(continued)*

Description of Violation

The resident-home contract, dated 11/11/2020, for Resident #1 was not signed by the resident.

Plan of Correction **Accept**

The contract was signed by Resident #1 and placed in the resident file.
The Executive Director or Designee will ensure all contracts with residents are signed by the residents, any designated person and the Executive Director or designee.
All new contracts will be audited monthly by Executive Director or Designee to ensure all signatures are completed over the next 6 months.
The Administrator will complete an audit of all resident records to ensure that each resident has a current signed contract in place . Any contact without the required signatures will be corrected. The audit and correction of all contracts will be done by August 31, 2021.

Completion Date: *08/31/2021*

63a - First Aid/CPR Training

1. **Requirements**

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 4/14/2021 from 11:00 PM to 7:00 AM on 4/15/2021, 65 residents were present in the home. During this time there was one staff person present who is currently trained and certified in first aid and CPR.

On 4/16/21 From 11:00 PM to 7:00 AM on 4/17/21, 65 residents were present in the home. During this time there was one staff person present who is trained in First Aid and CPR and one staff person who is trained in CPR only.

Plan of Correction **Accept**

The Healthcare Director or designee will ensure at least one staff person to every 50 residents is trained in CPR and First Aid on the daily schedules per each shift.
The daily schedules will be monitored to ensure compliance on each shift by the Healthcare Director or Designee.
The Healthcare Director had more staff trained in CPR and First Aid to ensure compliance.

Completion Date: *05/30/2021*

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.

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

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 Persons A, B, C, D and G have not received orientation in 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.

Plan of Correction **Accept**

Staff A- hire date [redacted] completed Training Sign off sheet 5/3/21
Staff B-hire date [redacted] -completed Training Sign off sheet 5/3/21
Staff C-hire date [redacted] -resigned employment
Staff D-hire date [redacted] -completed Training Sign off sheet 6/9/21
Staff G- hire date [redacted] completed Training Sign off sheet 5/3/21

Administrator or Designee will ensure all new staff receive required First Day Trainings on the day of Orientation and will monitor compliance on a monthly basis with Coworker file audits over the next 6 months.
Staff person training will also be included in the home Quality Management Review every month.

Completion Date: *06/25/2021*

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:

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.

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

Description of Violation

Staff Persons A, B, C, D, F and G have not received orientation training in the following:
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.

Plan of Correction **Accept**

Staff persons A, B, C, D, F, and G completed required trainings on 5/3/21 and 6/9/21.

Administrator or Designee will ensure staff receive the required trainings with in 40 scheduled working hours and will monitor monthly through Co-Worker File audits over the next 6 months.

Staff A, B, C, D, F. G had required training completed on 5/3/2021 and 6/9/2021 to be in compliance.

Administrator or Designee will ensure all staff receive required trainings with in the 40 scheduled working hours and will be monitored monthly by Co-Worker file audits for all new Co-Workers over the next 6 months
Staff person training will also be included in the home's Quality Management review every month.

Completion Date: *06/25/2021*

65c - Ancillary Staff Orientation

1. **Requirements**

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Staff Persons A, B, C, D, F and G who all perform ancillary duties in addition to direct care duties did not have a general orientation to his/her specific ancillary job functions.

Plan of Correction **Accept**

Staff persons A, B, C, D, F,, and G whom perform ancillary duties received the required trainings on 5/3/2021 and 6/9/2021.

The Administrator or Designee will monitor to ensure all staff persons receive general orientation to the ancillary duties with their job functions and will complete monthly audits of new staff files over the next 6 months.
Staff person training will also be included in the home's Quality Management Reviews every month.

Completion Date: *06/25/2021*

65d - Initial Direct Care Training

1. **Requirements**

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 Persons A and B provide unsupervised ADL services. However, the staff persons did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction **Accept**

Staff persons A and B completed the Direct Care Training Course on 4/30/2021.
Direct Care Staff persons will complete and pass the Department approved direct care training course prior to providing unsupervised ADL services and the Administrator or Designee will will ensure all newly hired direct care staff will complete and pass the Department required direct care training course and the new direct care staff files will be audited monthly to ensure completion of the training over the 3 months.
Staff person training will also be included in the home's Quality Management Review every month.

Completion Date: *06/25/2021*

105g - Lint Removal and Duct Cleaning

1. **Requirements**

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 4/27/21, two Speed Queen dryers in the 2nd floor laundry room and one Speed Queen dryer in the third floor laundry had an accumulation of lint in the lint traps. There were no clothes in the dryers at the time.

Plan of Correction **Accept**

The lint was removed upon discovery on 4/27/2021 from the lint trap of the dryer on the third floor.
Signage placed in laundry rooms to remind staff to clean dryer lint traps after each use.
Sign off sheet placed in laundry rooms for staff to sign that they cleaned the lint trap in the dryer after each use.
Maintenance Director or Designee will monitor and check the Sign of sheet weekly to ensure staff are indicating they cleaned the dryer lint trap after each use
Maintenance Director or Designee will complete spot checks weekly to ensure the dryer lint traps are free of any lint over the next 3 months.

Completion Date: *06/08/2021*

141a 1-10 Medical Evaluation Information

1. **Requirements**

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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 medical evaluation for Resident #9, with exam date 3/25/21, does not include information in the fields for blood pressure, temperature, height, pulse rate, body positioning and the date that the form was completed.

Plan of Correction **Accept**

The medical evaluation for Resident #9 dated 3/25/21 was forwarded to the Physician to complete the fields for blood pressure, temperature, height, pulse rate, body positioning, and date the form was completed.

The Healthcare Director or Designee will monitor all medical evaluations for residents to ensure all fields on the medical evaluation are completed by the physician.

The Healthcare Director or Designee will conduct monthly resident chart audits to ensure Medical Evaluations are completed in their entirety by the physicians over the next 6 months.

Completion Date: *05/06/2021*

183b - Meds and Syringes Locked

1. **Requirements**

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

A bottle of fish oil capsules and a vial of Amoxicillin prescribed to a non-resident of the home were on a counter top and table in the room of Resident #10. Resident #10 is unable to self administer medications however, these medications were accessible to this resident.

183b - Meds and Syringes Locked *(continued)*

Plan of Correction **Accept**

The bottle of fish oil capsules and the vial of Amoxicillin were removed and secured from Residents apartment upon discovery by the Healthcare Director. The Executive Director and Healthcare Director notified the POA in regards to regulatory procedures for any medications for residents whom can not self administer medications.
Resident #10 Physician was notified to get a current prescription of the 2 medications for Resident #10.
Healthcare Director or Designee will monitor resident apartments for any unsecured medications on a daily basis and remove and secure the medications over the next 6 months.

Completion Date: *04/29/2021*

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 Repeat Violation

The following blood glucose levels were recorded in the MAR (medication administration record) for Resident #11; however, none of these readings were recorded in the resident's glucometer:

Date & Time	*blood glucose level*
4/21/21 2:00 PM	*102*
4/26/21 8:00 AM	*116*
4/27/21 2:00 PM	*264*
4/27/21 8:00 PM	*125*

Repeated Violation - 2/10/20

Plan of Correction **Accept**

Blood glucose levels recorded on the MAR will match the recordings on the residents glucometer.

The Healthcare Director or Designee will audit the residents glucometer readings to ensure they match the recorded blood glucose levels recorded on the MAR on a weekly basis and address any areas of concern over the next 3 months.

Medication Technicians were trained on the proper procedures for glucometers and recording blood glucose readings on the MAR by the Healthcare Director.

The results of the medication audits will be discussed at the home's periodic quality management review every 3 months.

Completion Date: *07/25/2021*

186b - Medication Used by Resident

1. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

A vial of prescribed Amoxicillin was on a table top in the room of Resident #10. The prescription for the Amoxicillin was for a person who is not a resident of the home.

Plan of Correction **Accept**

The vial of Amoxicillin was removed from Resident #10 apartment and secured by the Healthcare Director. POA was notified that Resident #10 has a vial of Amoxicillin in her apartment that was prescribed to another individual and not Resident #10 and that the medication was removed from the apartment.
Physician for Resident #10 was notified of the medication and requested a prescription for the Amoxicillin in Resident #10 name.
Healthcare Director or Designee will monitor residents apartments daily to ensure proper policies are followed for all medications for residents over the next 3 months

Completion Date: *04/29/2021*

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Repeat Violation

Resident #11 is prescribed Carvedilol 6.25 mg at 8 AM and 8 PM, with directions to take the pulse and hold if pulse is under 60. The MAR (medication administration record) for Resident #11 has recorded pulse as "N/A" on 3/1 and 3/7/21.

Resident #2 is prescribed Novolog administered on a sliding scale with blood glucose levels checked at 8 AM, 12 PM and 5 PM. On 4/18/21, a blood glucose level was not obtained.

Resident #3 is prescribed Digoxin. However, this medication was not administered to Resident #3 on 4/26/21 because the medication was not available in the home.
Resident #3 is prescribed Potassium CL ER. This medication was not administered to Resident #3 on 4/20/21 because the medication was not available in the home.
Resident #13 is prescribed a Lidocaine pain patch daily. This was not administered to Resident #13 on 4/17/21 as it was not available in the home.

Resident #4 is prescribed Nitroglycerine, Acetaminophen, Benefiber, Diclofenac Sodium Gel, Polyethylene Glycol as needed. None of these medications were available in the home.

Repeated Violation - 10/13/20, 2/10/20

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

Plan of Correction **Accept**

Healthcare Director contacted the communities Pharmacy to have the medications for Resident # 3, #13, and #4 sent to the community so medications were available to administer as prescribed by the residents Physician.

Medication Technicians were educated by the Healthcare Director on proper medication administration and following prescribed parameters for specific medications for the Residents.
Healthcare Director educated Medication Technicians on proper documenting of blood glucose levels for residents
Healthcare Director or Designee will complete weekly audits of the MAR to ensure all medications are available as prescribed by the physicians and all documentation is entered on the MAR over the next 6 months.

The results of the medication audits will be discussed at the home's periodic quality management reviews every 3 months.

Completion Date: *06/25/2021*

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.

188b - Medication Error Reporting *(continued)*

Description of Violation

The following medication errors were not reported to each resident's physician:

Resident #2 did not receive prescribed Carbidopa-Levo, Duloxetine HCL, Mag-Tab SR, Metformin, Metoprolol Tartrate, Novolog and Pantoprazole Sod DR at 8:00 AM on 4/18/21.

Resident #3 did not receive prescribed Carbidopa-Levodopa, Buspirone HCL, Furosemide, Metoprolol Tartrate at 8 AM on 4/18/21.

Resident #4 did not receive prescribed Topiramate at 8:00 AM on 4/18/21.

Resident #5 did not receive prescribed Hydrocortisone, Levetiracetam, Sodium Chloride at 8:00 AM and Levothyroxine at 7:30 AM on 4/18/21.

Resident #6 did not receive prescribed Acetaminophen 500 mg, Breo Ellipta, Bupropion HCL, Divalproex Sod DR, Duloxetine HCL DR, Eliquis, Escitalopram, Famotidine, Fluticasone Prop, Lidocaine Patch, Magnesium Oxide, Risperidone and Topiramate at 8:00 AM on 4/18/21.

Resident #7 did not receive prescribed Carvedilol, Lorazepam and Pantoprazole Sod DR at 8:00 AM on 4/18/21.

Resident #8 did not receive prescribed Carvedilol at 8:00 AM on 4/18/21.

Resident #3 did not receive prescribed Potassium CL at 8:00 AM on 4/20/21 and Digoxin at 8:00 AM on 4/26/21.

Plan of Correction **Accept**

Medication errors will be reported to the residents prescribing physicians for follow and directives on the medications.
Resident #2, #3, #4, #5, #6, #7, #8, physicians were notified of the medication errors and follow up was received for missed medications.
Healthcare Director of Designee will ensure all medication errors are reported to the prescribing physicians upon discovery of the error.

The results of the medication audits will be discussed at the hoe's periodic quality management reviews every 3 months.

Completion Date: *06/25/2021*

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 #15 was admitted to the home on [redacted] but did not have an assessment completed until 11/17/2020.

Resident #6's assessment does not include the need for the 2 one-half bedrails which are attached to the resident's bed.

Plan of Correction **Accept**

Resident #6 physician was contacted for an order for the use of a bed assist rail and the need for a bed assist rail was added to the residents assessment.

New admitting residents will have an assessment completed with in 15 days of admission to the community.

Healthcare Director or Designee will ensure assessments are completed on al new residents with in 15 days of moving into the community and will monitor though residents chart audits on a monthly basis over the next 6 months.

The chart audits will ensure that all diagnoses and medical needs have been identified and addressed in the residents RASP
The administrator will develop and implement a tracking system to identify the initial and annual due dates of each resident assessment and support plan (RASP).

Completion Date: *08/31/2021*

225c - Additional Assessment

1. **Requirements**

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

The home completed an assessment for Resident #2 on 10/23/2020. The previous assessment was completed on 6/6/19.

Plan of Correction **Accept**

Annual assessments will be completed for all residents by the Healthcare Director or Designee on an annual basis and monitored through resident chart audits on a monthly basis over the next 6 months

The administrator will develop and implement a tracking system to identify the initial and annual due dates of each resident assessment and support plan (RASP) to ensure that all RASP's are done correctly, completely, and within the time frames required by this Chapter.

Completion Date: *08/31/2021*

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 #15 was admitted on [redacted] however, the resident's initial support plan was not completed until 11/17/2020.

Plan of Correction **Accept**

Initial support plans will be competed with in 30 days of a resident admitting into the community by the Healthcare Director or Designee and monitored through resident chart audits on a monthly basis over the next 6 months
The administrator will develop and implement a tracking system to identify the initial and annual due dates of each resident assessment and support plan RASP to ensure that all RASP's are done correctly, completely, and within the time frames required by this chapter.

Completion Date: *08/31/2021*

227d - Support Plan Medical/Dental

1. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The RASP for Resident #6 does not include a plan to protect the resident from the potential dangers of the 2 one-half bedrails that are in place on the resident's bed.

Plan of Correction **Accept**

Resident #6 RASP was updated on 4/30/2021 to include a plan to protect the resident from any potential harm with the utilization of the one bed enabler placed on [redacted] bed to assist [redacted] when getting into and out of bed as well as positioning while in the bed. A Physicians order was obtained for the utilization of the bed enabler.

An audit of RASP's will be conducted for all current residents to ensure that all medical needs have been identified and addressed. This audit will be completed by August 31, 2021.

Completion Date: *08/31/2021*

231b - Medical Evaluation

1. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

231b - Medical Evaluation *(continued)*

Description of Violation

Resident #12 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] however, the resident's medical evaluation does not indicate a diagnosis of Alzheimer's disease or other dementia.

Plan of Correction **Accept**

Resident #12 Physician was contacted in regards to a documented dementia diagnosis.
Residents being admitted into the secured dementia unit will have a documented diagnosis of dementia or Alzheimer's Disease by the physician.
Healthcare Director or Designee will monitor all secured dementia unit resident admissions medical evaluations to ensure it indicates a diagnosis of dementia or Alzheimer's Disease on an on going basis.

Completion Date: *06/10/2021*

231c - Preadmission Screening

1. **Requirements**

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] A written cognitive preadmission screening was not completed for this resident.

Plan of Correction **Accept**

Resident #1 cognitive preadmission screening was completed on 11/16/2020
The Healthcare Director or Designee will ensure all new residents admitting into the secured dementia unit will have a preadmission screening competed with in 72 hours prior to admission to the secured dementia unit.
Healthcare Director or Designee will ensure compliance with the preadmission screening by completing resident chart audits monthly over the next 6 months.

If the home determines that the resident's needs cannot be met by the home based on the preadmission screening, the home will refer the resident to the appropriate local assessment agency.

Completion Date: *06/25/2021*

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 #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident has not objected to the admission.

231e - No Objection Statement *(continued)*

Plan of Correction **Accept**

Resident #1 designated person signed the approval for placement in dementia care unit on 11/11/20 ad Resident #1 signed approval for placement in dementia care unit on 6/10/21.
Administrator or Designee will ensure all admitting residents to the secured dementia unit will sign the approval for placement into dementia care unit on day of admission.
Administrator or Designee will monitor to ensure approvals are signed by residents residing in the secured dementia care unit on a monthly basis through resident file audits over the next 6 months.

Completion Date: *06/10/2021*

233c - Key-Locking Devices

1. **Requirements**

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Repeat Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the main door to the Secure Dementia Care Unit (SDCU), the door to the stairway, the door to the parking area or the gate from the courtyard.

Repeated Violation - 10/13/20

Plan of Correction **Accept**

All doors in the SDCU that are utilized as an entrance and exit have been marked with the access code near the key pads. on 4/29/21.

All doors in the SDCU will be monitored on a daily basis by the SDCU Manager or designee to ensure the code is located near the key pads at all exiting and entering doors to the SDCU.

Completion Date: *04/29/2021*

254a - Records Discharge/Active

1. **Requirements**

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 4/27/21, a binder containing resident care sheets, medication count sheets and internal incident reports for residents was on top of the medication cart in the Harmony Square, the home's secured dementia care unit. These documents were not secured and were accessible.

254a - Records Discharge/Active *(continued)*

Plan of Correction **Accept**

The binder is secured in the medication cart when not in use so it is not accessible due to the resident information in the binder. Staff have been educated on the importance to secure the binder in the medication cart when not in use.by the Healthcare Director.
Harmony Square Director or designee will monitor on a daily basis to ensure the binder is secured in the medication cart when not in use to ensure no confidential information is accessible over the next 3 months.

Completion Date: *04/30/2021*