Department of Human Services
Bureau of Human Service Licensing

June 7, 2021

[redacted] PRESIDENT & CEO
ARTIS SENIOR LIVING OF BETHEL PARK LLC
680 AMERICAN AVENUE, SUITE 101
KING OF PRUSSIA, PA 19406

RE: ARTIS SENIOR LIVING OF SOUTH HILLS
1001 HIGBEE DRIVE
BETHEL PARK, PA, 15102
LICENSE/COC#: 44916

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/22/2021, 03/24/2021, 03/29/2021, 04/01/2021 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 - PUBLIC

Facility Information

Name: *ARTIS SENIOR LIVING OF SOUTH HILLS* **Licen e #:** *44916* **Licen e Expiration Date:** *05/01/2021*
Addre : *1001 HIGBEE DRIVE, BETHEL PARK, PA 15102*
County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: **Phone:** *4125958917* **Email:**

Legal Entity

Name: *ARTIS SENIOR LIVING OF BETHEL PARK LLC*
Address: *680 AMERICAN AVENUE, SUITE 101, KING OF PRUSSIA, PA, 19406*
Phone: *4125958917* **Email:**

Certificate(s) of Occupancy

Type: *I-2* **Date:** *04/19/2018* **Issued By:** *Municipality of Bethel Park*

Staffing Hours

Re ident Support Staff: *51* **Total Daily Staff:** *153* **Waking Staff:** *115*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal,Complaint* **Exit Conference Date:** *04/01/2021*

Inspection Dates and Department Representative

03/22/2021 - On-Site:
03/24/2021 - On-Site:
03/29/2021 On Site
04/01/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: *72* **Re ident Served:** *51*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Entire home* **Capacity:** *72* **Residents Served:** *51*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *51*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *51* **Have Physical Disability:** *0*

Inspections / Reviews

03/22/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *05/07/2021*

5/12/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/14/2021*

5/18/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/21/2021*

6/7/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

17 - Record Confidentiality

1. **Requirements**

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 3/22/21 at 2:50 p.m., the following items were unlocked and unattended in the pantry area of the Kaufman Cottage neighborhood:

** There was a binder in the upper left side cabinet above desk labeled "Kaufmans narc Shift count" includes controlled substance sheets with prescription orders for residents #1 and #2.*

** On the desk was an orange binder titled "Care Partners Communication Book" with resident information to include:*

Diet orders for all residents

A list of 45 resident names that includes typed need such as resident #3 "walks, sometimes incontinent, Med pull-ups"; resident #4 "needs assistance (sometime 2) can walk, brief large"; resident #5 "Doesn't walk; stands; heavy wetter; Pull Up XL & XL Brief";

A photo of a resident with identifying information and a note that states "Please check every 30 minutes to ensure no elopement"

Handwritten communication notes summarizing shift highlights of residents.

Plan of Correction **Accept**

Magnetic locks were installed on the cabinets on 3/23/21. A picture was uploaded for review. Staff will be re-educated on the need to maintain resident privacy. Daily audits will be conducted daily for two weeks, by the Executive Director or designee, then twice-weekly for 2 weeks, then randomly, twice monthly. The results will be ncluded on the Quality Management report.

Completion Date: *06/04/2021*

Document Submission **Implemented**

Staff were re-educated, daily audits were conducted, findings were noted on the Quality report. documents uploaded

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.

Description of Repeat Violation

The Residency Agreement for Resident #5, admitted [redacted], was not signed by the resident; the agreement was not dated when signed by the resident's responsible party.

Repeat violation: 4/23/20, 8/22/19

25b - Contract Signatures *(continued)*

Plan of Correction **Accept**

The Residency Agreement for #5 will be signed by the resident. An audit will be conducted of all current files to dentify any others that are missing signatures. Any that are will be signed by the resident (if they are able) or signed by the Executive Director, as an attestation, if they are not able to sign. The results of the audit will be reported to the Quality Management Team. On a go-forward basis with each new Move-In, each Residency Agreement will be reviewed by both the Marketing Director, and the Executive Director, (as a check-and-balance system) to ensure the Resident adds their signature and dates the document. The results will be recorded in the Quality Management report.

Completion Date: *05/27/2021*

Document Submission **Implemented**

All current files were audited to identify ones in need of signatures. Signatures (or witnessed unable to sign) were obtained. New move-ins were also audited. Copies of audits uploaded. Findings noted on the Quality report.

25c13 - Complaint Procedure

1. **Requirements**

2600.

25.c. At a minimum, the contract must specify the following:

13. Written information on the resident's rights and complaint procedures as specified in § 2600.41 (relating to notification of rights and complaint procedures).

Description of Violation

Resident #5's Residency Agreement, completed [redacted], includes an addendum that includes written information on Resident Rights. The addendum was not signed by the resident. It was only signed by the resident's representative on 6/10/19.

Resident #6's Residency Agreement completed [redacted] includes an addendum that includes written information on Resident Rights. The addendum was not signed by the resident. It was only signed by the resident's power of attorney on 9/16/20.

Resident #9's Residency Agreement completed [redacted] includes an addendum that includes written information on Resident Rights. The addendum was not signed by the resident. It was only signed by the resident's power of attorney.

Plan of Correction **Accept**

The Residency Agreement Addendum (that contains written information on Resident Rights, including complaint procedure) has been revised to include a signature line for the Resident to sign. A copy has been uploaded for review. The form has also been placed on colored paper as a visual reminder to obtain the Resident's signature. On a go-forward basis, the Marketing Director and the Executive Director will both audit all new move-ins (as a check-and-balance) to ensure proper signatures are obtained. Signatures for Resident #5 and Resident #6 will be obtained. Resident #9 is no longer with our community). Additionally, an audit will be completed of all existing resident files to ensure they were properly signed by all residents who have the capacity to sign. For those who do not have the capacity to sign, a witness notation will be made indicating such. The results will be recorded on the Quality Management report.

Completion Date: *06/04/2021*

25c13 - Complaint Procedure *(continued)*

Document Submission **Implemented**

New move-ins were audited by the Administrator and the Marketing Director, copy uploaded for review. Findings were included on the Quality report. All existing files were audited and resident signatures were obtained (or witnessed unable to sign) for any that were missing the resident's signature

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 Repeat Violation

There was an addendum to resident #5's Residency Agreement completed on [redacted] and to resident #6's Residency Agreement completed on[redacted] entitled "Addendum to Admission Agreement: Policy Addressing Use of Cameras and Recording Devices" which indicates in the second paragraph "Under no circumstances are Artis' residents and visitors permitted to use a hidden camera or other discrete video or sound recording device on the facility's premises. This prohibition extends to the use of such devices within a resident's living space and all common areas." However, residents are permitted to install "hidden cameras" in private rooms without the home's knowledge.

Repeat violation: 8/22/19

Plan of Correction **Directed**

We have uploaded a copy of the policy to review. The policy does protect the privacy rights of our residents by ndicating that should a resident or visitor wish to take a photograph or video recording of a resident's living space, the resident's prior express written consent must first be obtained. Resubmitted with copy of the form.

Directed

mmediately the home shall update the policy to include: Residents may video record in their private rooms or with the written permission of all roommates in shared rooms. Residents may install "hidden cameras" in private rooms without the home's knowledge.

Completion Date: *05/11/2021*

Document Submission **Implemented**

The policy was revised to include the Directed verbiage. A copy has been uploaded.

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 3/18/21, there were 51 residents present in the home. However, there was only one staff person present in the home from 11:15 p.m. on 3/18/21 until 6:45 a.m. on 319/21 who is trained in first aid and certified in obstructed airway techniques and CPR.

63a - First Aid/CPR Training *(continued)*

Plan of Correction **Accept**

An audit was conducted to identify the CPR status for all direct care givers. The audit confirmed we have at least two CPR trained staff on both the daylight and the evening shifts. The audit identified that we do not always have two CPR and First Aid trained staff on the overnight shift. Therefore, CPR and First Aid training has been scheduled on 5/14/2021 for the overnight staff as well as any additional staff whose CPR has expired. To ensure compliance going forward, the CPR status list will be reviewed, monthly by the Executive Director and the findings will be included in the Quality Management report. Note: At this this time, there are only 49 residents in the home.

Completion Date: *05/14/2021*

Document Submission **Implemented**

All of the overnight staff have received CPR training. An audit of all direct care staff reveals that all, but four, direct caregivers have current CPR cards. Another CPR training was set for June 8th to pick up for those remaining. The audit confirms that we have more than 2 CPR certified staff per shift, each day.

64a - Admin Training

1. **Requirements**

2600.

64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:

1. An orientation program approved and administered by the Department.

Description of Violation

Staff person A, the home's administrator, does not have documentation of attending an orientation program approved and administered by the Department.

Plan of Correction **Accept**

The home's administrator has documentation (Certificate of Achievement of attending the Personal Care Home Administrator Orientation Program held on September 13, 2013. The document is signed by [redacted] - Regional Licensing Director. The document has been uploaded for viewing.

Completion Date: *05/10/2021*

Document Submission **Implemented**

he document has been uploaded for review.

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 3/22/21 at approximately 10:50 a.m., there was evidence of what appears to be water damage to the ceiling in the hallway of the Core area of the home near the Neighborhood Center to include a 4" diameter brownish circle, peeling paint and cracking drywall at a drywall seam and at a sprinkler head.

88a - Surfaces *(continued)*

Plan of Correction **Accept**

On 4/30/21, Centimark inspected the roof leak area and found 4 punctures in TPO membrane and additionally found flashing leaking. Areas were cleaned and repairs were made by welding patches over holes and corners by using 12" flash TPO product. Following this repair, however, the area continued to leak. We contacted the mechanical contractor who identified an additional problem related to a leaking condenser unit. We are currently awaiting confirmation of the parts needed as well as the work completion date. We have informed the contractor that we are expecting repairs to be completed by June 4.

Completion Date: *06/04/2021*

Document Submission **Implemented**

The leak has been resolved and the ceiling has been repaired. A copy of the work invoice is uploaded for review.

89b - Hot Water Temperature

1. **Requirements**

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 3/22/21 at 12:05 p.m., the water temperature at the sink in the common bathroom in the Core area of the home measured 133.3 degrees Fahrenheit.

Plan of Correction **Accept**

On 3/23/2021, the home's maintenance engineer installed a mixing valve to resolve the problem. Temperatures will be checked, by the Director of Environmental services (or designee) daily for 2 weeks and then twice weekly for 2 weeks and then checked, randomly, twice monthly to ensure compliance. The results will be included on the Quality Management report.

Completion Date: *06/04/2021*

Document Submission **Implemented**

Daily temperature checks were conducted, after the mixing valve was added, and each one has been within limits, ranging from 108 to 110 degrees.

107b - Emergency Procedures

1. **Requirements**

2600.

107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident’s designated person.
2. The home’s plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.

107b - Emergency Procedures *(continued)*

Description of Violation

The home's emergency preparedness plan posted in a binder in the main lobby of the home did not include the following information:
(1) Contact information for each resident's designated person [or where to locate the information in an emergency].
(2) The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
(3) Contact telephone number of local and state emergency management agencies and local resources for housing and emergency care of residents.
(4) Means of transportation in the event that relocation is required.

Plan of Correction **Accept**

mmediately following the inspection, the binder was updated to include: 1) where to locate each resident's designated person, 2) the home's plan to provide emergency medical information, 3) contact telephone number of ocal and state emergency management agencies, local resources for housing and emergency care of residents, and 4) means of transportation in the event that relocation is required. Note: The home did have all of that information ncluded in a policy & procedure but it was not included in the lobby binder.

Completion Date: *06/04/2021*

Document Submission **Implemented**

The binder was immediately updated to include the missing information and that information has been uploaded for review.

121a - Unobstructed Egress

1. **Requirements**

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 3/22/21 at 11:22 a.m., the emergency exit door at the end of the hallway next to the Hartwood Acres neighborhood was difficult to open after overriding the magnetic lock due to a propane gas grill, 2 iron double shepherd hooks and 1 iron garden flag holder lying across the sidewalk just outside of the door. The items were blocking the egress route along the sidewalk.

Plan of Correction **Accept**

The items at the end of the hallway next to the Hartwood Acres neighborhood were immediately removed on 3/22/21. Staff will be educated on the requirements of 2600.121 a. The Director of Environmental Services will conduct an audit of all exit doors once daily for 2 weeks and then twice weekly for two weeks and then randomly each week. The results will be reported to the Quality Management Team.

Completion Date: *06/04/2021*

Document Submission **Implemented**

Daily audits were conducted and no additional egress obstructions were found. A copy of the audit has been uploaded for review.

130h - Inoperable Smoke Detector

1. **Requirements**

2600.

130h - Inoperable Smoke Detector *(continued)*

130.h. The home’s emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

On 4/1/21 at 11:15 a.m., the home s emergency procedures did not indicate the procedures that will be immediately implemented until an inoperable smoke detector or fire alarm is operable.

Plan of Correction **Accept**

On 4/1/21, the home's emergency procedure binder located in the lobby was updated to include the procedures that will be immediately implemented until the smoke detector or fire alarms are operable. A copy of the procedure has also been uploaded for review.

Completion Date: *04/01/2021*

Document Submission **Implemented**

A copy of the policy has been added to the Emergency Preparedness Plan binder and a copy uploaded for review.

184a - Labeling OTC/CAM

1. **Requirements**

2600.

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

Description of Repeat Violation

Resident #7 is prescribed Novolog sliding scale coverage with meals as follows: 0-150=0U; 151-200=6U; 201-250=8U; 251-300=10U; 301-350=12U; 351-400=14U; 401+ call MD. However, on 3/24/21 at 10:20 a.m., there was a clear zipper bag with a pharmacy label for resident #7 that indicates Novolog Flexpen syringe – inject 4 units sub-Q three times daily before meals.

Repeat violation 8/22/19

Plan of Correction **Accept**

Resident #7's pharmacy label has been corrected. Additionally, An audit of each medication cart will be completed against the Medication Administration Record to ensure that no other discrepancies are found. The audit will be conducted by the DHW (or designee) once weekly for the next 4 weeks and then twice monthly for the next two months and then once monthly thereafter. The results of each audit will be reported to the Quality Management Team. Nurses and MedTechs will be re educated on their portion of responsibility for ensuring the 9 elements of medication administration are reviewed and followed, including the need for the labels to exactly match the prescription as ordered.

Completion Date *06/04/2021*

Document Submission **Implemented**

Medication cart audits were performed on 5/14, 5/21, 5/25 and 6/3. The findings were noted. Medication administration staff were educated on the errors and the requirements of the code. Copies of the audit and findings were uploaded and copies of the education sheet was uploaded. Audit findings were included on the Quality report.

187a - Medication Record

1. **Requirements**

2600.

187a - Medication Record *(continued)*

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

Description of Violation

Resident #7 is prescribed Acetaminophen 500mg – Take 1 tab by mouth every 6 hours as needed for pain. However, on 3/24/21 at 10:30 a.m., there was an entry on the resident's March 2021 medication administration record (MAR) for Acetaminophen 325mg – take two tablets by mouth every four hours as needed for temperature.

Repeat violation 8/22/19

Plan of Correction **Accept**

Resident #7's order for 325mg Acetaminophen as needed was discontinued 3/25/21. An audit of each medication cart will be completed against the Medication Administration Record to ensure that no other discrepancies are found. The audit will be conducted by the DHW (or designee) once weekly for the next 4 weeks and then twice monthly for the next two months and then once monthly thereafter. The results of each audit will be reported to the Quality Management Team. Nurses and MedTechs will be re-educated on their portion of responsibility for ensuring the 9 elements of medication administration are reviewed and followed.

Completion Date: *06/04/2021*

Document Submission **Implemented**

Medication cart audits were performed on 5/14, 5/21, 5/25 and 6/3. The findings were noted. Medication administration staff were educated on the errors and the requirements of the code. Copies of the audit and findings were uploaded and copies of the education sheet was uploaded. Audit findings were included on the Quality report.

187d Follow Prescriber's Orders

1. **Requirements**

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

Description of Violation

Resident #8 is prescribed Vitamin D2 1.25mg (50,000unit) capsule – Take 1 capsule by mouth once a month on the 12th [starting August 2019]. On 3/24/21 at 10:55 a.m., there was a blister pack of this medication with 1 green capsule to be administered on the 12th of the month. The resident's March 2021 MAR indicates that the medication was not administered on 3/12/21 at 9:00 a.m. due to not being available in the home. The pharmacy was notified and the medication was delivered during the 3:00 p.m. – 11:00 p.m. shift on 3/12/21. However, the medication was not administered to the resident until 3/24/21.

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

Plan of Correction **Accept**

This medication error was reported to the DHS on 3/24/2021. A copy of the report was uploaded for view. An audit of each medication cart will be completed against the Medication Administration Record to ensure that no other discrepancies are found. The audit will be conducted by the Director of Health and Wellness or a designee. Nurses and MedTechs will be re-educated on how to record, in the electronic MAR, instances whereby a medication is prescribed only once-monthly (i.e. we have 30 days to administer it), but it's not actually in-house on the administration day indicated in the MAR.

Completion Date: *06/04/2021*

Document Submission **Implemented**

Medication cart audits were performed on 5/14, 5/21, 5/25 and 6/3. The findings were noted. Medication administration staff were educated on the errors and the requirements of the code. Copies of the audit and findings were uploaded and copies of the education sheet was uploaded. Audit findings were included on the Quality report.

191 - Resident Right to Refuse

1. **Requirements**

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #5's Residency Agreement includes an addendum with written information on Resident Rights to include the right to question or refuse a medication if the resident believes there may be a medication error. The addendum was not signed by the resident. It was only signed by the resident's representative on [redacted]

Resident #6's Residency Agreement completed [redacted] *includes an addendum with written information on Resident Rights to include the right to question or refuse a medication if the resident believes there may be a medication error. The addendum was not signed by the resident. It was only signed by the resident's power of attorney.*

Resident #8's Residency Agreement completed [redacted] *includes an addendum with written information on Resident Rights to include the right to question or refuse a medication if the resident believes there may be a medication error. The addendum was not signed by the resident. It was only signed by the resident's power of attorney.*

Resident #9's Residency Agreement completed [redacted] *includes an addendum with written information on Resident Rights to include the right to question or refuse a medication if the resident believes there may be a medication error. The addendum was not signed by the resident. It was only signed by the resident's power of attorney.*

There is no other documentation that the residents were educated of their right to question or refuse a medication if they believe there may be a medication error.

191 - Resident Right to Refuse *(continued)*

Plan of Correction **Accept**

The Residency Agreement form (which includes the right to question or refuse a medication if the resident believes there may be a medication error) has been revised to include a signature line for the Resident to sign. A copy of the form has been uploaded for view. The form has also been placed on colored paper as a visual reminder to obtain the Resident's signature. The Marketing Director and the Executive Director , as a check-and-balance, will both audit all new move-ins to ensure proper signatures are obtained. Signatures will be obtained for Residents #5, #6 and #8. (Resident #9 is no longer with the community). Additionally, an audit will be completed of all existing resident files to ensure they were properly signed by all residents who have the capacity to sign. For those who do not have the capacity to sign, a witness notation will be made indicating such. The results will be recorded on the Quality Management report.

Completion Date: *06/04/2021*

Document Submission **Implemented**

An audit of every chart was conducted to identify any that were missing the resident's signature. Signatures (or witnessed refusal) were obtained for ones that were missing the signature. We utilized the monthly Town Hall meeting as a time to educate residents about their right to refuse a medication if they believe an error was made. Audits of new move-ins will be conducted to ensure all future move-ins are educated about their rights, and the right to refuse medication. Copies of the audits were uploaded for review

225c - Additional Assessment

1. **Requirements**

2600.

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

1. Annually.

Description of Violation

The annual assessment for resident #5, completed on 9/25/2020, does not include the resident's needs for the following topics in Section 4: Social and Recreational Needs: hobbies/interests, solitary activities, group activities, religious affiliation, if any. These sections were blank.

The annual assessment for resident #9, completed on 10/12/2020, does not include the resident's needs in the following topics in Section 4: Social and Recreational Needs: hobbies/interests, solitary activities, group activities, religious affiliation, if any. These sections were blank.

Plan of Correction **Accept**

The annual assessment for resident #5 has been updated to include Section 4. Resident #9 is no longer with the community. For all future move-ins, both the Executive Director and the Director of Health and Wellness (as a check-and-balance system) will conduct an audit, within 72 hours of each move-in date, to ensure the Admission and Support Plans are properly developed and documented in the resident record. For all current residents, the Director of Health & Wellness (or designee) will conduct an audit of each resident record to identify whether or not any additional records are found to be non-compliant for documentation and dating. Any found incomplete will be completed and the audit results will be reported to the Quality Management Team.

Completion Date: *05/26/2021*

225c - Additional Assessment *(continued)*

Document Submission **Implemented**

An audit was conducted of the Social/Reactional secdtion to ensure they were complete and timely dated. As a team we decided it would be best to have the Director of Life Enrichment complete those sections so we have incorporated that into our process. The results were included on the Quality report. The audits will continue for all new move ins and those results will be reported on the Quality report as well. copies of the audit were uploaded for review.

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 #6's preadmission screening, completed on [redacted], included a cognitive screening which was not completed until [redacted]

Plan of Correction **Accept**

For all future move-ins, both the Director of Health & Wellness and the Executive Director will function as a "check-and-balance" team, each reviewing the preadmission screening form to ensure it is completed within 72 hours prior to admission. Additionally, an audit will be conducted of each preadmission screen currently on file to identify any that were dated outside of the 72 hour window. The audit will be conducted by the Director of Health and Wellness, or designee. The results of that audit will be reported to the Quality Management Team.

Completion Date: *06/04/2021*

Document Submission **Implemented**

An audit was conducted of all Pre-Admission screenings to ensure they were complete and timely dated. The results were included on the Quality report. The audits will continue for all new move ins and those results will be reported on the Quality report as well. copies of the audit were uploaded for review.

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 Violation

On 3/22/21 at 10:55 a.m., the directions posted for operation of the magnetically locked exit door near room #[redacted] in the Kaufman Cottage neighborhood were not conspicuous. The code was difficult for Department licensing representative to decipher.

On 3/22/21 at 10:58 a.m., there were no directions posted for operation of the magnetically locked courtyard gate outside of Kaufman Cottage neighborhood that leads from the enclosed courtyard to the sidewalk and parking area in the front of the building.

233c - Key-Locking Devices *(continued)*

Plan of Correction **Accept**

The directions for all of the magnetically locked exit doors have been restyled to make them more conspicuous. A copy has been uploaded for view. Additionally, the code for the operation of the magnetically locked courtyard gates has been posted at the bottom of each gate door.

Completion Date: *05/14/2021*

Document Submission **Implemented**

The code for the operation of the magnetically locked courtyard gates has been posted at the bottom of each gate door. A picture has been uploaded for review.

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 Repeat Violation

Resident #7 was admitted to the home on [redacted]. However, the resident's initial support plan was not finalized until [redacted].

Repeat violation 3/6/2020

Plan of Correction **Accept**

For all future move-ins, both the Executive Director and the Director of Health and Wellness (as a check-and-balance system) will conduct an audit, within 72 hours of each move-in date, to ensure the Admission and Support Plans are properly developed and documented in the resident record. For all current residents, the Director of Health & Wellness (or designee) will conduct an audit of each resident record to identify whether or not any additional records are found to be non-compliant for documentation and dating and those results will be reported to the Quality Management Team.

Completion Date: *06/04/2021*

Document Submission **Implemented**

An audit was conducted of all RASPs to ensure they were complete and timely dated. Several were found to be ncomplete and were immediately corrected. The results were included on the Quality report. The audits will continue for all new move ins and those results will be reported on the Quality report as well. copies of the audit were uploaded for review.