# Department of Human Services
# Bureau of Human Service Licensing

September 29, 2021

[redacted], ADMINISTRATOR
LAFAYETTE MANOR INC LMI
145 LAFAYETTE MANOR ROAD
UNIONTOWN, PA 15401

RE: BEECHWOOD COURT AT LAFAYETTE MANOR
145 LAFAYETTE MANOR ROAD
UNIONTOWN, PA, 15401
LICENSE/COC#: 40961

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 07/14/2021, 07/15/2021 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,
[redacted]

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:** *BEECHWOOD COURT AT LAFAYETTE MANOR* **License #:** *40961* **License Expiration Date:** *10/03/2021*
**Address:** *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA 15401*
**County:** *FAYETTE* **Region:** *WESTERN*

## Administrator

**Name:** [redacted] **Phone:** *7244346024* **Email:** [redacted]

## Legal Entity

**Name:** *LAFAYETTE MANOR INC LMI*
**Address:** *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA, 15401*
**Phone:** *7244346024* **Email:** [redacted]

## Certificate(s) of Occupancy

**Type:** *C-2 LP* **Date:** *09/27/2000* **Issued By:** *Labor and Industry*

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *57* **Waking Staff:** *43*

## Inspection

**Type:** *Full* **Notice:** *Unannounced* **BHA Docket #:**
**Reason:** *Renewal* **Exit Conference Date:** *07/15/2021*

## Inspection Dates and Department Representative

*07/14/2021 - On-Site:* [redacted]
*07/15/2021 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *64* **Residents Served:** *46*

### Secured Dementia Care Unit

**In Home:** *Yes* **Area:** *SDCU* **Capacity:** *23* **Residents Served:** *11*

### Hospice

**Current Residents:** *6*

### Number of Residents Who:

**Receive Supplemental Security Income:** *0* **Are 60 Years of Age or Older:** *46*
**Diagnosed with Mental Illness:** *0* **Diagnosed with Intellectual Disability:** *0*
**Have Mobility Need:** *11* **Have Physical Disability:** *0*

## Inspections / Reviews

### 07/14/2021 - Full

**Lead Inspector:** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date**: *09/22/2021*

### 9/22/2021 - POC Submission

**Lead Reviewer:** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date**: *09/28/2021*

### 9/29/2021 - POC Submission

**Lead Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date**: *10/31/2021*

## 26a - Quality Management Plan

1. **Requirements**

2600.
26.a. The home shall establish and implement a quality management plan.

**Description of Violation**

*The home has not conducted a quality management review within the past year.*

**Plan of Correction** **Directed**

*Administrator will in the future be sure to follow Quality Management Policy. Administrator will begin this Quality management plan immediately and continue through out the year. This plan will address reportable incidents, complaint procedures, violations. The administrator will follow the forms provided in attachments. See attachments 13 a-e*

*DIRECTED: Within 7 days of receipt of the plan of correction: The home shall conduct a quality management review which covers all topics specified in 2600.26b. Documentation of the quality management review shall be kept. ██ 9/29/21*

*DIRECTED: Within 7 days of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure a quality management review is conducted at least annually. Documentation of the system and quality management reviews shall be kept. LM 9/29/21*

**Completion Date:** *09/27/2021*

## 42p - Restraints

1. **Requirements**

2600.
42.p. A resident shall be free from restraints.

**Description of Violation**

*Bilateral half-length bedrails were present at the top of resident #2's bed; however, the resident was unable to demonstrate the ability to use the device. The resident resides in the home's secured dementia care unit (SDCU).*

*Bilateral half-length bedrails were present at the top of resident #7's bed; however, the resident was unable to demonstrate the ability to use the device. The resident resides in the home's SDCU.*

*Bilateral half-length bedrails were present at the top of resident #8's bed; however, the resident was unable to demonstrate the ability to use the device. The resident resides in the home's SDCU.*

*Bilateral half-length bedrails were present at the top of resident #11's bed; however, the resident was unable to demonstrate the ability to use the device. The resident resides in the home's SDCU.*

## 42p - Restraints *(continued)*

**Plan of Correction** **Directed**

*Administrator will inquire upon admission if the resident uses a hospital bed whether they can demonstrate how to use the bed rails. If resident does not have the ability to independently use the bed rail the administrator will work with resident, family and physician to find an alternative to bed rails. All residents who currently use bedrails will be asked to demonstrate the use of them and if unable Administrator will begin the process of working with families and physician to find other ways for resident to position themselves in bed. (DIRECTED: Within 7 days of receipt of the plan of correction: An alternative should be found for all current residents who are unable to demonstrate the use of bedrails. The bedrails shall be removed from the bed of any resident who is unable to demonstrate the use of the bedrails. ██ 9/29/21)*

*DIRECTED: Within 7 days of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure no bedrails are placed on a resident's bed who is unable to demonstrate the use of the bedrails. The system shall include an assessment tool to determine the most appropriate adaptive equipment, such as a bed cane, for residents to use for repositioning and transferring in/out of bed/chair. Documentation of the system shall be kept. Residents who use any adaptive equipment on their beds shall be assessed at least quarterly to ensure safe use of the adaptive equipment. Resident assessments and support plans shall be updated for all residents who use adaptive equipment on their bed. ██ 9/29/21*

**Completion Date:** *10/15/2021*

## 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 person A was hired on ██████; however, A Pennsylvania criminal background check was not completed until ██████.*

*No Pennsylvania criminal background check was completed for staff person B, who was hired on ██████.*

## 51 - Criminal Background Check *(continued)*

**Plan of Correction** **Directed**

*Administrator will check all staff files to be certain all background checks are in the file. Administrator will begin the use of a new hire checklist to be certain that all information including background checks are in the new hires file. Administrator will also go through all existing employee files to be certain that all components are in the files. administrator will include a checklist to all existing files as they are checked to ensure compliance with background checks. All checks of existing files will be completed by October 30, 2021 (DIRECTED: Documentation of the new-hire checklist shall be kept in each staff person's record. ██ 9/29/21)*

*DIRECTED: Within 48 hours of receipt of the plan of correction: A Pennsylvania criminal background check shall be completed for staff person B. Documentation of the results of the criminal background check shall be kept in staff person B's record. ██ 9/29/21*

**Completion Date:** *10/30/2021*

## 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.

**Description of Violation**

*Staff person A, hired on ██████, did not receive training on the following topics:*

** Emergency medical plan*

** Mandatory reporting of abuse and neglect under the Older Adults Protective Services*

** Reporting of reportable incidents and conditions*

**Plan of Correction** **Directed**

*Administrator will begin immediately to use a new hire checklist to be sure all that all new staff has training in Emergency Management plan, Mandatory reporting of abuse and reporting of reportable incidents. (DIRECTED: The new hire checklist shall include all topics specified in 2600.65b. ██ 9/29/21) New hires will not be permitted to begin work until all trainings are completed and charted with dates of completion. Administrator will check all existing employees files for the documentation of new hire trainings. (DIRECTED: The review of all current staff records shall be completed by 10/30/21. ██ 9/29/21). Administrator will sign off on checklist as the files are checked for accuracy. This checklist will become a part of the employee file. During these checks if any employee is missing any of the trainings they will be immediately pulled from direct care until trainings are completed and dated. See attachment # 14*

*DIRECTED: Within 5 days of receipt of the plan of correction: Staff person A shall receive training on all topics specified in 2600.65b. Documentation of the training shall be kept in staff person A's record. ██ 9/29/21*

**Completion Date:** *10/15/2021*

## 85a - Sanitary Conditions

1. **Requirements**

2600.
85.a. Sanitary conditions shall be maintained.

**Description of Violation**

*On 7/15/21, there was an unlabeled loofa in the shared shower of resident #3 and resident #4.*

**Plan of Correction** **Directed**

*Administrator will conduct a training on Sanitary conditions for all staff including housekeeping. This training will be finished on October 15, 2021. This training will include sanitary conditions within a shared bathroom . Housekeeping will trained to be aware of the shared bathrooms and to check them more frequently for any unsanitary condition. (DIRECTED: The housekeeping checks shall occur daily. ██ 9/29/21). Administrator will also do spot checks weekly for any conditions that need to be addressed by housekeeping and/or staff. Administrator will conduct these checks weekly for 1 month and then monthly for 3 months. Administrator will sign off when each check is finished and discuss findings with all staff.*

*DIRECTED: Within 24 hours of receipt of the plan of correction: The unlabeled shower loofa in the shared bathroom of residents #3 and #4 shall be removed. ██ 9/29/21*

**Completion Date:** *12/30/2021*

## 86a - Ventilation

1. **Requirements**

2600.
86.a. All areas of the home that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

**Description of Violation**

*On 7/15/21, the exhaust fan in resident #5's bathroom was inoperable. There is no operable window in this bathroom.*

*On 7/15/21, the exhaust fan in resident #6's bathroom was inoperable. There is no operable window in this bathroom.*

*On 7/15/21, the exhaust vent in the shared bathroom of resident #7 and resident #8 is clogged and does not allow air to flow through. There is no operable window in this bathroom.*

**Plan of Correction** **Accept**

*Administrator had maintenance check all vents throughout the building. Head of maintenance went on the roof and checked fans and found a fan not working. He said the fan will be replaced immediately. Administrator will have maintenance check all vents on a quarterly basis and sign off that they were checked and any issues they may find. This will be an ongoing check. See attachment #5*

**Completion Date:** *09/21/2021*

## 91 - Telephone Numbers

1. **Requirements**

2600.

## 91 - Telephone Numbers *(continued)*

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

**Description of Violation**

*On 7/15/21, there were no emergency telephone numbers posted on or near resident #2's telephone.*

*On 7/15/21, there were no emergency numbers posted on or near resident #3's telephone.*

**Plan of Correction** **Accept**

*Administrative assistant had housekeeping check all rooms and replace any missing emergency cards. Administrator will have housekeeping do monthly checks in all rooms and replace any missing emergency numbers. Administrator will also have housekeeping document on a form that they were checked monthly for the next 6 months. See attachment #6.*

**Completion Date:** *09/21/2021*

## 101j7 - Lighting/Operable Lamp

1. **Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

**Description of Violation**

*On 7/15/21, resident #2's bedside lamp was approximately 4 feet from resident's bed and could not be turned on/off at bedside.*

*On 7/15/21, resident #3's bedside lamp was approximately 5 feet from bed and could not bed turned on/off at bedside.*

*On 7/15/21, no operable lamp or other source of lighting was present at resident #7's bedside.*

## 101j7 - Lighting/Operable Lamp *(continued)*

**Plan of Correction** **Directed**

*Administrator will do weekly checks of all rooms to ensure that lamps are at bedside. This checks will be done weekly for 4 weeks, (DIRECTED: The checks shall be completed monthly after the weekly checks for 4 weeks are completed. Documentation of the checks shall be kept. ██ 9/29/21)*
*Bedside lamp checks will be documented by administrator on a bedside lamp check sheet. Any lamps found out of place will be immediately restored to the bedside. Administrator will also purchase lights that can be adhered to the wall beside each bed to ensure that there is night time lighting for all residents. This will be in addition to bedside lamps. See attachment #16*

*DIRECTED: Within 48 hours of receipt of the plan of correction: An operable lamp or other source of lighting shall be within reach of resident's #2, #3 and #7's beds. ██ 9/29/21*

*DIRECTED: By 10/15/21: All staff persons shall be educated that each resident shall have an operable lamp or other source of lighting within reach of their bed. Documentation of the education shall be kept. ██ 9/29/21*

**Completion Date:** *10/29/2021*

## 102i - Soap Dispenser

1. **Requirements**

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

**Description of Violation**

*On 7/15/21, there was unlabeled bar of soap in the shared bathroom of resident #3 and resident #4.*

**Plan of Correction** **Directed**

*Administrator will do weekly checks of all soap dispensers to ensure that they are filled and that there is no bar soap without clearly marked containers in the shared bathrooms. This weekly check will be documented for 4 weeks on Bathroom check list. Housekeeping and staff will be trained on regulation 102i. The training will be documented and kept in personal file.*

*DIRECTED: By 10/15/21: The administrator will conduct a training on sanitary conditions for all staff including housekeeping, which includes ensuring there are no unlabeled bars of soap in shared bathrooms. Housekeeping will trained to be aware of the shared bathrooms and to check them daily for any unsanitary conditions, which includes ensuring there are no unlabeled bars of soap in shared bathrooms. Documentation of the education shall be kept. LM 9/29/21*

*DIRECTED: Within 24 hours of receipt of the plan of correction: The unlabeled bar of soap in the shared bathroom of residents #3 and #4 shall be removed. ██ 9/29/21*

**Completion Date:** *10/15/2021*

## 102k - No Common Towel

1. **Requirements**

2600.
102.k. Use of a common towel is prohibited.

## 102k - No Common Towel *(continued)*

**Description of Violation**

*On 7/15/21, there was an unlabeled towel hanging on the towel rack in the shared bathroom of resident #3 and resident #4.*

*On 7/15/21, there was an unlabeled towel hanging on the towel rack in the shared bathroom of resident #7 and resident #8.*

**Plan of Correction** **Directed**

*Administrator will during weekly checks of shared bathrooms ensure that there are no unmarked towels. These checks will be done weekly for one month and documented on bathroom check list. All towel bars in shared bathroom will be clearly marked with residents name. Paper towel dispensers will also be filled as needed by housekeeping for hand washing.*

*DIRECTED: By 10/15/21: The administrator will conduct a training on sanitary conditions for all staff including housekeeping, which includes ensuring there are no unlabeled towels present in shared bathrooms. Housekeeping will trained to be aware of the shared bathrooms and to check them daily for any unsanitary conditions, which includes ensuring there are no unlabeled towels present in shared bathrooms. Documentation of the education shall be kept. LM 9/29/21*

*DIRECTED: Within 24 hours of receipt of the plan of correction: The shared towels in the shared bathroom of residents #3 and #4, as well as the shared bathroom of residents #7 and #8, shall be removed. 9/29/21*

**Completion Date:** *10/28/2021*

## 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 7/14/21 at 9:46 am, the lint trap in the dryer of 2nd floor laundry room was completely covered in lint.*

**Plan of Correction** **Directed**

*Immediately administrator will retrain staff to remove lint after every use of dryers. (DIRECTED: Documentation of the education shall be kept. 9/29/21)*
*Immediately: A signature sheet will be hung in every laundry room. Staff will immediately sign off at the end of each shift that lint was removed. See attachment 13 (DIRECTED: A designated staff person shall review the daily sign off sheets. 9/29/21)*

*DIRECTED: Within 48 hours of receipt of the plan of correction: A designated staff person shall inspect all dryers daily for 4 weeks then weekly thereafter to ensure lint is removed from the lint trap after each use. 9/29/21*

**Completion Date:** *09/28/2021*

## 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**

*Bilateral half-length bedrails were present at the top of resident #10's bed; however, the resident's most recent medical evaluation, dated [redacted], only indicates the use of a wheeled walker.*

*Resident #10's most recent medical evaluation, dated [redacted], does not include a medication addendum. This section of the form is blank.*

*REPEAT VIOLATION: 1/6/2021*

**Plan of Correction** **Directed**

*Immediately administrator will check all Medical evaluations for accuracy of information. (DIRECTED: The review shall include the review of resident #10's current medical evaluation. [redacted] 9/29/21) Immediately all medical evaluations that are incorrect will be corrected and signed by physicians for approval of any changes. Administrator will document on Admission checklist that the Medical evaluation was checked for accuracy. All medical evaluations will go through the check by October 28, 2021 see attachment 18 (DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons involved in the admission process shall be educated on reviewing all medical evaluations for completeness. Documentation of the education shall be kept. [redacted] 9/29/21)*

*DIRECTED: Beginning on 10/28/21: A designated staff person shall review at least 10 resident medical evaluations monthly to ensure each resident has an accurate medical evaluation, completed in its entirety, within 60 days prior to admission or within 30 days after admission. [redacted] 9/29/21*

**Completion Date:** *10/28/2021*

## 141b1 - Annual Medical Evaluation

1. **Requirements**

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

## 141b1 - Annual Medical Evaluation *(continued)*

**Description of Violation**

*Resident #2's most recent medical evaluation was completed [redacted]. Also, bilateral half-length bedrails were present at the top of resident #2's bed; however, the resident's most recent medical evaluation, dated [redacted], indicates "listed below" under the body positioning/movement section; however, nothing is listed.*

*Resident #3's most recent medical evaluation was completed on [redacted].*

*Resident #11's most recent medical evaluation was completed on [redacted] Also, bilateral half-length bedrails were present at the top of resident #11's bed; however, the resident's most recent medical evaluation, dated [redacted] indicates "none" under the body positioning/movement section.*

**Plan of Correction** **Directed**

*Administrator will immediately begin checks of all medical evaluations for accuracy of information. Administrator will have all corrections completed by October 28, 2021. (DIRECTED: The administrator will document on Admission checklist that the medical evaluations were checked for accuracy. [redacted] 9/29/21). Immediately all Medical evaluations will be checked for dates of completion. Residents #3, #2, and #11 medical evaluations will be immediately updated by administrator. These updated medical evaluations will be completed by October 1, 2021.*

*DIRECTED: Within 7 days of receipt of the plan of correction: A new medical evaluation shall be completed for residents #2, #3 and #11. Documentation of the completed medical evaluations shall be kept in residents #2 , #3 and #11's records. [redacted] 9/29/21*

*DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons involved in the admission process shall be educated on reviewing all medical evaluations for completeness. Documentation of the education shall be kept. [redacted] 9/29/21)*

*DIRECTED: Beginning on 10/28/21: A designated staff person shall review at least 10 resident medical evaluations monthly to ensure each resident has an accurate medical evaluation, completed in its entirety, at least annually. [redacted] 9/29/21*

*DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a tracking system to ensure each resident has a medical evaluation completed in its entirety at least annually. Documentation of the tracking system shall be kept. All staff persons involved in the medical evaluation process shall be*
*educated on the new tracking system. Documentation of the education shall be kept. [redacted] 9/29/21*

**Completion Date:** *10/28/2021*

## 162c - Menus Posted

1. **Requirements**

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

## 162c - Menus Posted *(continued)*

**Description of Violation**

*On 7/14/21, The only menu posted in a public and conspicuous place was dated 7/12/21 through 7/18/21.*

**Plan of Correction** **Accept**

*Administrator immediately spoke with Head of Dietary and all menus will be sent via e-mail to administrator for posting. Activities director will also receive menus for entire month from dietary as a backup to administrator so that menus are posted accurately at all times. Administrator will check menus daily when arriving to be sure 2 weeks are posted at all times*

**Completion Date:** *09/28/2021*

## 171b5 - First Aid Kit

1. **Requirements**

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

**Description of Violation**

*The first aid kit in the home's van does not have a thermometer, scissors, eye coverings, breathing shield or tweezers*

*REPEAT VIOLATION: 8/20/2019*

**Plan of Correction** **Accept**

*Administrator immediately replaced entire first aid kit in the van. Activities director will check first aid kit with each use of activity van and also will check first aid kit monthly if van was not used in that month. These checks will be documented on a van usage log , See attachment #8. Any missing items during this check will be replaced immediately and also documented,*

**Completion Date:** *09/28/2021*

## 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 Violation**

*Resident #6 is prescribed [redacted] with meals in addition to sliding scale coverage. On 7/11/21 at 3:59 pm, the resident's blood glucose was 237; however, this blood glucose reading was not documented on resident #6's July 2021 medication administration record (MAR).*

## 185a - Implement Storage Procedures *(continued)*

**Plan of Correction** **Directed**

*Immediately the administrator will train staff member involved on documentation on MAR. (DIRECTED: Documentation of the education shall be kept. ██ 9/29/21). Staff member will also retake diabetic training as it is made available. Administrator will check Resident #6 MAR for accuracy weekly for one month.*

*DIRECTED: Within 48 hours of receipt of the plan of correction, then weekly thereafter: A designated staff person shall review the glucometers and medication administration records for all residents who receive blood sugar checks to ensure all prescribed blood sugar checks are taken in accordance with prescribers' orders and are accurately documented on resident medication administration records. ██ 9/29/21*

**Completion Date:** *10/28/2021*

## 187d - Follow Prescriber's Orders

1. **Requirements**

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

**Description of Violation**

*Resident #6 is prescribed ██████ with meals in addition to sliding scale coverage. However, the resident's blood glucose was not taken before dinner on 7/8/21, so it is unable to be determined if insulin should have been administered.*

*Resident #6 is prescribed ██████ in the evening except skip Tuesdays; however, this medication was not administered on the evening of 7/8/21.*

*Resident #6 is prescribed ██████ once a day; however, this medication was not administered on 7/12/21, because it was not available in the home.*

*REPEAT VIOLATION: 8/20/2019*

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

**Plan of Correction** **Directed**

*Immediately all staff will have documentation training to ensure that MAR's are being signed appropriately. and all meds are given on time. (DIRECTED: Documentation of the education shall be kept. 9/29/21). Immediately administrator will assign 2 staff members to check all medication carts. weekly. (DIRECTED: The weekly review shall include ensuring all prescribed medications are present in the home for administration, are administered in accordance with prescriber's orders and are documented as administered on resident medication administration records. 9/29/21) They will report to Administrative assistant any medication issues with carts. Administrative assistant will be responsible for re-ordering any medication as needed.*

*DIRECTED: Within 48 hours of receipt of the plan of correction, then weekly thereafter: A designated staff person shall review the glucometers and medication administration records for all residents who receive blood sugar checks to ensure all prescribed blood sugar checks are taken in accordance with prescribers' orders and are accurately documented on resident medication administration records. 9/29/21*

**Completion Date:** *09/30/2021*

## 221c - Post Activity Calendar

1. **Requirements**

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

**Description of Violation**

*On 7/14/21, the only activity calendar posed in a public and conspicuous place was dated 7/4/21 through 7/10/21.*

**Plan of Correction** **Accept**

*Activities director will immediately begin to post a monthly activity calendar to ensure that residents are aware of any activities for the month to avoid any issues if activities director should be absent from work. Administrator will check that activities calendar is posted at the first of each month*

**Completion Date:** *09/28/2021*

## 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**

*No assessment was completed for resident #9, who was admitted to the home on .*

*Resident #10's most recent assessment, dated , indicates the resident is independent with transferring in/out of bed/chair, turning and positioning in bed/chair and ambulating; however, bilateral half-length bedrails were present at the top of resident #10's bed.*

*REPEAT VIOLATION: 1/6/2021*

## 225a - Assessment 15 Days *(continued)*

**Plan of Correction** **Directed**

*Administrator will immediately check all assessments for accuracy and make any and all corrections immediately. (DIRECTED: The administrator review shall include updating resident #10's assessment. The updated assessment shall be kept in resident #10's record. 9/29/21) Administrator will in the future check all assessments for accuracy as they are being done.*

*DIRECTED: Within 5 days of receipt of the plan of correction: A new assessment shall be completed for resident #9. The completed assessment shall be kept in resident #9's record. 9/29/21*

*DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall add to the home's new admission checklist that each resident has an assessment completed in its entirety within 15 days of admission. Documentation of the new admission checklist shall be kept in each resident's record. 9/29/21*

*DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure resident assessments are updated as resident care needs change. All staff persons involved in the assessment process shall be educated on the new system. Documentation of the education shall be kept. 9/29/21*

**Completion Date:** *09/28/2021*

## 225c - Additional Assessment

1. **Requirements**

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

**Description of Violation**

*Resident #2's most recent assessment was completed on*

*Resident #3's most recent assessment was completed on*

*Resident #6's most recent assessment was completed on .*

*Resident #11's most recent assessment was completed on*

## 225c - Additional Assessment *(continued)*

**Plan of Correction** **Directed**

*Administrator will immediately check all assessments and update all as needed, Administrator will immediately have residents 2,3,6, and 11 assessments done by October 15, 2021. The check of the assessments for all Residents will be completed by October 30, 2021*

*DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a tracking system to ensure each resident has an assessment completed in its entirety at least annually. Documentation of the tracking system shall be kept. All staff persons involved in the assessment process shall be educated on the new tracking system. Documentation of the education shall be kept. ███ 9/29/21*

**Completion Date:** *10/30/2021*

## 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**

*No support plan was completed for resident #9, who was admitted to the home on ███*

*REPEAT VIOLATION: 1/6/2021*

**Plan of Correction** **Directed**

*Administrator will immediately check all support plans and update any and all for accuracy. Resident #9 support will be done immediately and all others will be checked and updated by October 30, 2021. (DIRECTED: Resident #9's support plan shall be kept in the resident's record. ███ 9/29/21). Administrator will in the future check all support plans as they are completed for accuracy. All checks will be documented on a sign off sheet by administrative assistant and administrator. In the future any and all support plans will be checked and added to the checklist. Check list will be kept in resident file.*

**Completion Date:** *10/29/2021*

## 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.

## 227d - Support Plan Medical/Dental *(continued)*

**Description of Violation**

*Resident #10's most recent assessment, dated [redacted], indicates the resident is independent with transferring in/out of bed/chair, turning and positioning in bed/chair and ambulating; however, bilateral half-length bedrails were present at the top of resident #10's bed and the resident's most recent support plan, dated [redacted], does not address the need for the bedrails or plan to protect the resident from the potential dangers of the bedrails.*

*Bilateral half-length bedrails were present at the top of resident #11's bed; however, the resident's most recent support plan, dated [redacted], does not address the need for the bedrails or plan to protect the resident from the potential dangers of the bedrails.*

*Bilateral half-length bedrails were present at the top of resident #12's bed; however, the resident's most recent support plan, dated [redacted], does not address the need for the bedrails or plan to protect the resident from the potential dangers of the bedrails.*

**Plan of Correction** **Directed**

*Administrator well immediately begin checks of all support plans for accuracy. In future if resident is admitted and/or becomes in need of bedrails a support plan will be updated to reflect the change. This updated support plan will also be signed off on the check list that will be added to resident file.*

*DIRECTED: Within 5 days of receipt of the plan of correction: The support plans for residents #10, #11 and #12 shall be updated to accurately reflect their care needs. The completed support plans shall be kept in residents #10, #11 and #12's records. [redacted] 9/29/21*

*DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure resident support plans are updated as resident care needs change. All staff persons involved in the support plan process shall be educated on the new system. Documentation of the education shall be kept. [redacted] 9/29/21*

**Completion Date:** *10/29/2021*

## 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 #3 was admitted to the home's SDCU on [redacted]; however, the resident's most recent medical evaluation is dated [redacted]. Also, resident #3's most recent medical evaluation does not indicate the need for the resident to be served in the home's SDCU.*

*Resident #7 was admitted to the home's SDCU on [redacted]; however, no medical evaluation was completed. Also, bilateral half-length bedrails were present at the top of resident #7's bed; however, no documentation is present from resident #7's physician recommending the use of the bilateral half-length bedrails.*

*Resident #8 was admitted to the home's SDCU on [redacted]; however, no medical evaluation was completed. Also, bilateral half-length bedrails were present at the top of resident #8's bed; however, no documentation is present from resident #8's physician recommending the use of the bilateral half-length bedrails.*

*Bilateral half-length bedrails were present at the top of resident #13's bed; however, the resident's most recent medical evaluation, dated [redacted], indicates "none" under the body positioning/movement section.*

*REPEAT VIOLATION: 8/20/2019; 9/20/2019*

**Plan of Correction** **Directed**

*Administrator will immediately have all medical evaluations for the above mentioned residents done to reflect use of bedrails. Physician orders will be added to any resident file that require bedrails and the reason for the bedrails. Administrator will begin checking all medical evaluations for accuracy. These checks will be signed off on the checklist in residents file (DIRECTED: On a monthly basis, the administrator or designated staff person shall review the records of all residents admitted to the home's SDCU within that month to ensure each resident admitted to the home's SDCU has a medical evaluation completed in its entirety within 60 days prior to admission. [redacted] 9/29/21)*

*DIRECTED: Within 7 days of receipt of the plan of correction: Medical evaluations shall be completed for residents #3, #7 and #8, which includes documentation of the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in the SDCU. Resident #13's medical evaluation shall be returned to the physician to be updated. Copies of the completed medical evaluations shall be kept in residents #3, #7, #8 and #13's records. [redacted] 9/29/21*

*DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall add to the home's new admission checklist that each resident admitted to the home's SDCU has a medical evaluation completed in its entirety, which includes documentation of the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in the SDCU, within 60 days prior to admission. Documentation of the new admission checklist shall be kept in each resident's record. [redacted] 9/29/21*

**Completion Date:** *10/29/2021*

## 231c - Preadmission Screening

1. **Requirements**

## 231c - Preadmission Screening *(continued)*

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 #3 was admitted to the home's SDCU on [redacted] however, no cognitive preadmission screening was completed.*

*Resident #7 was admitted to the home's SDCU on [redacted]; however, the resident's cognitive preadmission screening was completed on [redacted]*

*Resident #13 was admitted to the home's SDCU on [redacted]; however, the resident's cognitive preadmission screening is undated, so it is unable to be determined if it was completed within 72 hours prior to admission.*

*REPEAT VIOLATION: 8/20/2019; 9/20/2019*

**Plan of Correction** **Directed**

*Administrator will check all pre-admission screenings for accuracy and will in the future ensure that physicians are given pre-admission screenings as soon as possible before admission. (DIRECTED: The review of resident records shall be completed by 10/30/21. [redacted] 9/29/21). In the future no resident will be admitted to SDCU until pre-admission screening is done and dated by physician.*

*DIRECTED: Within 7 days of receipt of the plan of correction: Cognitive preadmission screenings shall be completed for residents #3 and #13. The completed cognitive preadmission screenings shall be kept in residents #3 and #13's records. [redacted] 9/29/21*

*DIRECTED: Beginning on 10/1/21: On a monthly basis, the administrator or designated staff person shall review the records of all residents admitted to the home's SDCU within that month to ensure each resident admitted to the home's SDCU has a cognitive preadmission screening completed within 72 hours prior to admission. [redacted] 9/29/21)*

*DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall add to the home's new admission checklist that each resident admitted to the home's SDCU has cognitive preadmission screening completed in its entirety within 72 hours prior to admission. Documentation of the new admission checklist shall be kept in each resident's record. [redacted] 9/29/21*

**Completion Date:** *10/28/2021*

## 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.

## 234a - Admission Support Plan *(continued)*

**Description of Violation**

*Resident #7 was admitted to the home's SDCU on [redacted]; however, the resident's support plan was not completed until [redacted]. Also, bilateral half-length bedrails were present at the top of resident #7's bed; however, the resident's most recent support plan, dated [redacted], does not address the need for the bedrails or plan to protect the resident from the potential dangers of the bedrails.*

*Resident #8 was admitted to the home's SDCU on [redacted]; however, the resident does not have a completed support plan.*

*Resident #13 was admitted to the home's SDCU on [redacted]; however, the resident's support plan was not completed until [redacted]. Also, bilateral half-length bedrails were present at the top of resident #13's bed; however, the resident's most recent support plan, dated [redacted], does not address the need for the bedrails or plan to protect the resident from the potential dangers of the bedrails.*

**Plan of Correction** **Directed**

*Administrator will only admit to SDCU if the admission support plan is finished 72 hours prior to admission. If cannot be done 72 hours prior then resident will be admitted only during week days so that admission support plan can be done by administrative assistant within the required 72 hours. All admission support plans will be signed of on the check list to show accuracy in time frames. Administrator will check admission support plans for residents of SDCU for accuracy and this will be done with any new admission,*

*DIRECTED: Within 5 days of receipt of the plan of correction: A support plan shall be completed for resident #8. A copy of the completed support plan shall be kept in the resident's record. [redacted] 9/29/21*

*DIRECTED: Within 5 days of receipt of the plan of correction: The support plans for residents #7 and #13 shall be updated to accurately reflect their care needs. The completed support plans shall be kept in residents #7 and #13's records. [redacted] 9/29/21*

*DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall add to the home's new admission checklist that each resident admitted to the home's SDCU has a support plan completed in its entirety within 72 hours of admission, or within 72 hours prior to admission. Documentation of the new admission checklist shall be kept in each resident's record. [redacted] 9/29/21*

**Completion Date:** *10/15/2021*

## 234b - Support Plan Needs Elements

1. **Requirements**

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

**Description of Violation**

*Bilateral half-length bedrails were present at the top of resident #2's bed; however, the resident's most recent support plan, dated [redacted], does not address the need for the bedrails or plan to protect the resident from the potential dangers of the bedrails.*

## 234b - Support Plan Needs Elements *(continued)*

**Plan of Correction** **Directed**

*Administrator will immediately update #2 support plan to include the use of bedrails for positioning. All support plans for residents with bedrails will be checked for accuracy as well as adding a physician order stating need for bedrails. (DIRECTED: The review of resident support plans shall be completed by 10/30/21. The review of resident support plans shall also include a review of the entire support plan to ensure they accurately reflect resident care needs. ███ 9/29/21). Families will be informed of the dangers of bedrail use in a letter administrator will send. This letter will be sent to all families by October 30, 2021*

*DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure resident support plans are updated as resident care needs change. All staff persons involved in the support plan process shall be educated on the new system. Documentation of the education shall be kept. ███ 9/29/21*

**Completion Date:** *10/29/2021*

## 251b - Record Entries Legible

1. **Requirements**

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

**Description of Violation**

*Correction fluid was used on the resident name and date of birth sections of resident #10's most recent medical evaluation, dated ███.*

**Plan of Correction** **Directed**

*The administrator will check all medical evaluations for any use of correction fluid. Administrator will immediately have any medical evaluation that has correction fluid replaced. In the future administrator will carefully check any and all medical evaluations for errors and be sure that they are legible.*

*DIRECTED: Within 7 days of receipt of the plan of correction: All staff persons shall be educated that the use of correction fluid on resident records is not permitted. Documentation of the education shall be kept. ███ 9/29/21*

**Completion Date:** *10/15/2021*