Department of Human Services
Bureau of Human Service Licensing

April 11, 2022

[redacted] EXECUTIVE DIRECTOR
[redacted]

RE: ATRIA BETHLEHEM
1745 WEST MACADA ROAD
BETHLEHEM, PA, 18017
LICENSE/COC#: 22281

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/24/2021, 08/25/2021, 08/26/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance 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

Facility Information

Name: *ATRIA BETHLEHEM* **License #:** *22281* **License Expiration:** *10/16/2021*

Address: *1745 WEST MACADA ROAD, BETHLEHEM, PA 18017*

County: *NORTHAMPTON* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/28/1998* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *89* **Waking Staff:** *67*

Inspection Information

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Renewal* **Exit Conference Date:** *08/26/2021*

Inspection Dates and Department Representative

08/24/2021 - On-Site: [redacted]
08/25/2021 - On-Site:
08/26/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served:** *62*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *62*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *27* **Have Physical Disability:** *1*

Inspections / Reviews

08/24/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/14/2021*

08/24/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/22/2021*

02/16/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/25/2022*

04/11/2022 - Document Submission

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

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 2/24/21 resident #1 suffered a fall and was sent to the hospital. The resident returned the same day with sutures to the right side of the forehead. The home did not send an incident report for this fall until 3/1/21.

Plan of Correction ***Accept***

Incident reports that are reportable to the state will be completed in a timely manner according to state regulation.

Resident Services Director audited current incidents from the past 90 days, any issues found during the audit were addressed immediately to ensure compliance with regulation 2600 16c.
Resident Services Director and Executive Director were retrained on the requirement of state regulation 2600 16c on 8/30/2021, to ensure timely reporting of all incident and compliance with state regulation.
Executive Director will be responsible for ensuring community maintains compliance with regulation 2600 16c.
Executive Director will be meeting with Resident Services Director to review incident reports weekly for the next 90 days to ensure community is in compliance with regulation 2600 16
If a fax is unable to be sent, ED or RSD will call the hotline to at least report the incident within the required timeframe.

Plan of Correction ***Accept***

Incident reports that are reportable to the state will be completed in a timely manner according to state regulation.

Resident Services Director audited current incidents from the past 90 days, any issues found during the audit were addressed immediately to ensure compliance with regulation 2600 16c.
Resident Services Director and Executive Director were retrained on the requirement of state regulation 2600 16c on 8/30/2021, to ensure timely reporting of all incident and compliance with state regulation.
Executive Director will be responsible for ensuring community maintains compliance with regulation 2600 16c.
Executive Director will be meeting with Resident Services Director to review incident reports weekly for the next 90 days to ensure community is in compliance with regulation 2600 16
If a fax is unable to be sent, ED or RSD will call the hotline to at least report the incident within the required timeframe.

Document Submission ***Implemented***

See attaches staff training

28e - Death of a Resident

1. Requirements

2600.

28e - Death of a Resident *(continued)*

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #2 passed away on [redacted] The total payment made to the home for December was [redacted] The resident record indicates the resident's room was cleared of belongings on 12/13/20. The resident's family was due a refund for the remaining 18 days of the month based on the payment of $6245. The total refund due was [redacted] = [redacted]). The resident's family received a refund of [redacted] The resident's family did not receive an accurate refund from the home.

Plan of Correction ***Do Not Accept***

The resident was billed and paid $6,245.00 for the month of December 2020. The resident was moved out on 12/13/2020, so their prorated billing for the thirteen days based on the daily rate calculation was [redacted]. The remainder of their payment after the billing was adjusted for the move out was [redacted]), which was refunded back to the resident. Atria calculateed the daily rate as (monthly rate x 12 / 365).

Going forward, business office will calculate daily rate based on appropriate days in the month.

Update: *11/16/2021*

Who will be responsible for monitoring ongoing compliance? 11-16-2021 MM

Plan of Correction ***Accept***

The resident was billed and paid [redacted] for the month of December 2020. The resident was moved out on 12/13/2020, so their prorated billing for the thirteen days based on the daily rate calculation was [redacted]. The remainder of their payment after the billing was adjusted for the move out was [redacted]), which was refunded back to the resident. Atria calculateed the daily rate as (monthly rate x 12 / 365).
Going forward, business office will calculate daily rate based on appropriate days in the month. E.D. will be responsible for monitoring ongoing compliance.

Document Submission ***Implemented***

Going forward, business office will calculate daily rate based on appropriate days in the month. E.D. will be responsible for monitoring ongoing compliance.

57b - 1 Hour/Day

1. Requirements

2600.
57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On the following dates the home did not have sufficient direct care staff scheduled to provide a minimum of 1 hour per day of personal care services to each mobile resident:
On all 3 days the census was 62 residents with 27 immobile residents, requiring a minimum of 89 direct care hours:
On 8/9/21 82 hours of direct care services were provided.
On 8/15/21 86.5 hours of direct care services were provided.
On 8/21/21 68.5 hours of direct care services were provided.
The home did not contact the department's regional office regarding staffing shortages.

57b - 1 Hour/Day *(continued)*

Plan of Correction ***Accept***

The home immediately corrected the staffing to ensure compliance with state regulation.

Resident Services Director reviewed the current staffing schedules on 8/26/2021, to ensure community is staffing according to regulation 2600 57b. Any issues found during the audit were corrected immediately to ensure compliance.
Resident Services Director was retrained on regulation 2600 57b by the Executive Director on 8/26/21, to ensure community staffing schedule is within regulation.
Executive Director will be responsible for compliance with regulation 2600 57b. Executive Director will meet with Resident Services Director weekly for the next 90 days to review staffing schedules to ensure compliance.
3. 2600

Plan of Correction ***Accept***

The home immediately corrected the staffing to ensure compliance with state regulation.

Resident Services Director reviewed the current staffing schedules on 8/26/2021, to ensure community is staffing according to regulation 2600 57b. Any issues found during the audit were corrected immediately to ensure compliance.
Resident Services Director was retrained on regulation 2600 57b by the Executive Director on 8/26/21, to ensure community staffing schedule is within regulation.
Executive Director will be responsible for compliance with regulation 2600 57b. Executive Director will meet with Resident Services Director weekly for the next 90 days to review staffing schedules to ensure compliance.
3. 2600

Document Submission ***Implemented***

See attached community schedules

57c - 2 Hours/Day

1. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On the following dates the home did not have sufficient direct care staff scheduled to provide a minimum of 1 hour per day of personal care services to each mobile resident and 2 hours per day to each immobile resident:
On all 3 days the census was 62 residents with 27 immobile residents, requiring a minimum of 89 direct care hours:
On 8/9/21 82 hours of direct care services were provided.
On 8/15/21 86.5 hours of direct care services were provided.
On 8/21/21 68.5 hours of direct care services were provided.
The home did not contact the department's regional office regarding staffing shortages.

57c - 2 Hours/Day *(continued)*

Plan of Correction ***Accept***

The home immediately corrected the staffing to ensure compliance with state regulation.

Resident Services Director reviewed the current staffing schedules on 8/26/21, to ensure community is staffing according to regulation 2600 57c. Any issues found during the audit were corrected immediately to ensure compliance.
Resident Services Director was retrained on regulation 2600 57c by the Executive Director on 8/26/21, to ensure community staffing schedule is within regulation.
Executive Director will be responsible for compliance with regulation 2600 57c. Executive Director will meet with Resident Services Director weekly for the next 90 days to review staffing schedules to ensure compliance.

Plan of Correction ***Accept***

The home immediately corrected the staffing to ensure compliance with state regulation.

Resident Services Director reviewed the current staffing schedules on 8/26/21, to ensure community is staffing according to regulation 2600 57c. Any issues found during the audit were corrected immediately to ensure compliance.
Resident Services Director was retrained on regulation 2600 57c by the Executive Director on 8/26/21, to ensure community staffing schedule is within regulation.
Executive Director will be responsible for compliance with regulation 2600 57c. Executive Director will meet with Resident Services Director weekly for the next 90 days to review staffing schedules to ensure compliance.

Document Submission ***Implemented***

See attached community schedules

57d - Waking Hours

1. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On the following dates the home did not have sufficient direct care staff scheduled to provide at least 75% of care during waking hours:
On both days the census was 62 residents with 27 immobile residents, requiring a minimum of 89 direct care hours with at least 67 of those hours provided during waking hours, 7am to 11pm:
On 8/15/21 86.5 hours of direct care services were provided; 64 hours were provided during waking hours.
On 8/21/21 68.5 hours of direct care services were provided; 53.5 hours were provided during waking hours.
The home did not contact the department's regional office regarding staffing shortages.

Plan of Correction ***Accept***

The home immediately corrected the staffing to ensure compliance with state regulation.

Resident Services Director reviewed the current staffing schedules on 8/26/21, to ensure community is staff

57d - Waking Hours (continued)

according to regulation 2600 57d. Any issues found during the audit were corrected immediately to ensure compliance.
Resident Services Director was retrained on regulation 2600 57d by the Executive Director on 8/26/2021, to ensure community staffing schedule is within regulation.
Executive Director will be responsible for compliance with regulation 2600 57d. Executive Director will meet with Resident Services Director weekly for the next 90 days to review staffing schedules to ensure compliance.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Plan of Correction ***Accept***

The home immediately corrected the staffing to ensure compliance with state regulation.

Resident Services Director reviewed the current staffing schedules on 8/26/21, to ensure community is staff according to regulation 2600 57d. Any issues found during the audit were corrected immediately to ensure compliance.
Resident Services Director was retrained on regulation 2600 57d by the Executive Director on 8/26/2021, to ensure community staffing schedule is within regulation.
Executive Director will be responsible for compliance with regulation 2600 57d. Executive Director will meet with Resident Services Director weekly for the next 90 days to review staffing schedules to ensure compliance.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Document Submission ***Implemented***

Please see attached Staff Training Sheets addressing above POC
See attached schedules

60a - Staff/Support Plan

1. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

60a

The home has a census of 62 residents with 27 of those residents identified by the home as having mobility issues with regard to evacuation assistance. On 8/9/21, 8/10/21, 8/11/21, and 8/21/21 there were only 2 staff persons scheduled for the 3rd shift. The home did not schedule enough staff persons on 3rd shift for those days to accommodate the high number of immobile residents in the home.

Plan of Correction ***Accept***

The home immediately corrected the staffing to ensure compliance with state regulation.

Resident Services Director reviewed the current staff schedules on 8/26/2021, to ensure community is staff

60a - Staff/Support Plan (continued)

according to regulation 2600 60a. Any issues found during the audit was corrected immediately to ensure compliance.
Resident Services Director was retrained on regulation 2600 60a by the Executive Director on 8/26/2021, to ensure community staff schedule is within regulation.
Executive Director will be responsible for compliance with regulation 2600 60a. Executive Director will meet with Resident Services Director weekly for the next 90 days to review staffing schedule to ensure compliance.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Plan of Correction ***Accept***

The home immediately corrected the staffing to ensure compliance with state regulation.

Resident Services Director reviewed the current staff schedules on 8/26/2021, to ensure community is staff according to regulation 2600 60a. Any issues found during the audit was corrected immediately to ensure compliance.
Resident Services Director was retrained on regulation 2600 60a by the Executive Director on 8/26/2021, to ensure community staff schedule is within regulation.
Executive Director will be responsible for compliance with regulation 2600 60a. Executive Director will meet with Resident Services Director weekly for the next 90 days to review staffing schedule to ensure compliance.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Document Submission ***Implemented***

Please see attached Staff Training Sheets addressing above POC
See attached schedules

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 the following dates and times the home did not have at least 1 staff person with first aid and CPR certified training for every 50 residents in the home:
Census=62 requiring at least two staff persons trained in first aid and CPR for all shifts.
On 8/9/21 during the hours of 3pm to 5pm and from 11pm to 7am only 1 staff person with first aid/CPR training was present.
On 8/21/21 only 1 staff person with first aid/CPR training was present on 1st and 2nd shifts; on 3rd shift there were 2 staff persons scheduled and neither staff person had current first aid/CPR training.

Plan of Correction ***Do Not Accept***

Prior to receiving violation, First Aid and CPR training was scheduled to occur on 9/13. A diverse group of

63a - First Aid/CPR Training (continued)

employees attended the training provided by APlus Safety on 9/13/21, including employees from the Maintenance, Dietary, Wellness, and Engage Life departments. One of the dates mentioned, 8/9, was founded to have 2 CPR trained employees in the community. E.D. verified RSD covered a shift and passed meds during 11-7. CBD will notify E.D. and RSD 90 days in advance of CPR expiration to ensure a class is scheduled timely.

Update: *11/16/2021*

Who will be responsible to ensure that at least one staff person for every 50 residents is trained in first aid and certified in obstructed airway techniques and CPR and will be present in the home at all times? 11-16-2021 MM

Plan of Correction ***Accept***

Prior to receiving violation, First Aid and CPR training was scheduled to occur on 9/13. A diverse group of employees attended the training provided by APlus Safety on 9/13/21, including employees from the Maintenance, Dietary, Wellness, and Engage Life departments. One of the dates mentioned, 8/9, was founded to have 2 CPR trained employees in the community. E.D. verified RSD covered a shift and passed meds during 11-7. CBD will notify E.D. and RSD 90 days in advance of CPR expiration to ensure a class is scheduled timely. E.D. will be responsible to ensure at least one staff person for every 50 residents is trained in first aid and CPR.

Document Submission ***Implemented***

Prior to receiving violation, First Aid and CPR training was scheduled to occur on 9/13. A diverse group of employees attended the training provided by APlus Safety on 9/13/21, including employees from the Maintenance, Dietary, Wellness, and Engage Life departments. One of the dates mentioned, 8/9, was founded to have 2 CPR trained employees in the community. E.D. verified RSD covered a shift and passed meds during 11-7. CBD will notify E.D. and RSD 90 days in advance of CPR expiration to ensure a class is scheduled timely. E.D. will be responsible to ensure at least one staff person for every 50 residents is trained in first aid and CPR.

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.
2. A 100-hour standardized Department-approved administrator training course.
3. A Department-approved competency-based training test with a passing score.
4. Paragraphs (1), (2) and (3) do not apply to an administrator hired or promoted prior to October 24, 2005.

Description of Violation

Administrator A completed the required 100 hour department approved training course on 6/20/2007. Administrator A did not take a position as a personal care home administrator until April of 2021. Administrator A did not take the department approved competency based training test as required by this regulation.

Plan of Correction ***Accept***

E.D. immediately scheduled and completed 8-hour Administrator Orientation on 9/10 as recommended by the state surveyor. E.D. contacted [redacted], Program Manager of NCC to schedule PCHA exam, the class will be offered mid-Oct and completed at that time. A copy of completion will be forwarded to BHSL.

Update: *11/16/2021*

Please send/Attach proof of the department approved competency based training test as required by this regulation. 111-16-2021 MM

Plan of Correction ***Accept***

E.D. immediately scheduled and completed 8-hour Administrator Orientation on 9/10 as recommended by the

64a - Admin Training (continued)

state surveyor. E.D. contacted [redacted], Program Manager of NCC to schedule PCHA exam, the class will be offered mid-Oct and completed at that time. A copy of completion will be forwarded to BHSL.

Update: *11/16/2021*

Please send/Attach proof of the department approved competency based training test as required by this regulation. 111-16-2021 MM

Document Submission ***Implemented***

Please see attached Staff Training Sheets addressing above POC

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

The glucometer belonging to resident #3 had dried blood on it.
Also, resident #3's glucometer was used to check the blood sugar of resident #4 on 8/23/21 at 10am.

Plan of Correction ***Do Not Accept***

When brought to the RSD's attention, glucometer was immediately cleaned. Staff was retrained 8/26, 8/27 and 9/1 on sanitary procedures. Alcohol wipes were placed in every machine pouch to prompt cleaning after every use. Incident report for using the incorrect glucometer on a resident was completed and given to inspector immediately. Physician notified, as well as resident and family member. All monitors were checked to ensure each one is now labeled with the resident's name to reduce chance of errors.

Update: *11/16/2021*

Who specifically will be responsible for monitoring compliance regarding resident's glucometers and maintaining sanitary conditions? 11-16-2021 MM

Plan of Correction ***Accept***

When brought to the RSD's attention, glucometer was immediately cleaned. Staff was retrained 8/26, 8/27 and 9/1 on sanitary procedures. Alcohol wipes were placed in every machine pouch to prompt cleaning after every use. Incident report for using the incorrect glucometer on a resident was completed and given to inspector immediately. Physician notified, as well as resident and family member. All monitors were checked to ensure each one is now labeled with the resident's name to reduce chance of errors. Resident Services Director will be responsible for monitoring compliance regarding glucometers and maintaining sanitary conditions.

Document Submission ***Implemented***

Please see attached Staff Training Sheets addressing above POC

103g - Storing Food

1. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

Three large tubs of ice cream were stored in a portable ice cream freezer with no lids on the tubs. Three bowls of garden salads were stored in the refrigerator with no covering over the salads. A bag of powdered sugar was found on a shelf in

103g - Storing Food (continued)

the pantry open and not sealed properly.

Plan of Correction ***Accept***

Upon discovery of the uncovered items, the ice cream tubs, garden salads, and powdered sugar were immediately sealed. Additionally, all culinary employees were retrained on this regulation 9/3 and 9/4 to ensure all food is stored in closed or sealed containers. Compliance with regulation 2600.103 (g) is the responsibility of the Administrator, Culinary Director, or designee on a daily basis.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Plan of Correction ***Accept***

Upon discovery of the uncovered items, the ice cream tubs, garden salads, and powdered sugar were immediately sealed. Additionally, all culinary employees were retrained on this regulation 9/3 and 9/4 to ensure all food is stored in closed or sealed containers. Compliance with regulation 2600.103 (g) is the responsibility of the Administrator, Culinary Director, or designee on a daily basis.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Document Submission ***Implemented***

Please see attached Staff Training Sheets addressing above POC

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

The exit door located at the first floor stairwell A required heavy force to open it due to a metal piece at the bottom of the door sticking.

Plan of Correction ***Do Not Accept***

DHS surveyor, [redacted] explained during the exit interview that this issue was immediately fixed by our Maintenance Director. MD removed the metal piece of the door to prevent sticking.

Update: *11/16/2021*

What systems will be put in place by the home to monitor for ongoing compliance of this regulation? Who will be responsible for ongoing compliance?
11-16-2021 MM

Plan of Correction ***Accept***

DHS surveyor, [redacted] explained during the exit interview that this issue was immediately fixed by our Maintenance Director. MD removed the metal piece of the door to prevent sticking. E.D. and Manager on Duty will

121a - Unobstructed Egress (continued)

walk the building as a part of daily routine to make sure stairways, doorways, passageways, and egress routes from rooms and from the building are unlocked and unobstructed. E.D. is responsible for ongoing compliance.

Document Submission ***Implemented***

DHS surveyor, [redacted] explained during the exit interview that this issue was immediately fixed by our Maintenance Director. MD removed the metal piece of the door to prevent sticking. E.D. and Manager on Duty will walk the building as a part of daily routine to make sure stairways, doorways, passageways, and egress routes from rooms and from the building are unlocked and unobstructed. E.D. is responsible for ongoing compliance.

141a 1-10 Medical Evaluation Information

1. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The Documentation of Medical Evaluation (DME) form for resident #4 dated [redacted] was missing the height and weight of the resident.

Plan of Correction ***Do Not Accept***

Since this violation, Sales Director provided pre-move in and DME training on 9/6/2021 to Administrative Assistant, the process is as follows: CSD either informs family to bring DME to physician appointment, or faxes DME to office. Once completed DME is returned to the community, AA will deliver to E.D. or RSD to ensure accuracy. If form is missing information, AA will re-fax and call the doctor to explain items needed for compliance

Update: *11/16/2021*

What was done to immediately fix the violation? What systems were put in place by the home to prevent future violations and who will monitor for ongoing compliance? 11-16-2021 MM

Plan of Correction ***Accept***

To immediately fix the violation, DME was faxed to the physician to add height and weight. Since this violation, Resident Services Director, LPN or Resident Services Supervisor, LPN reviews all DME's prior to residents moving into the community to ensure accuracy. RSD or RSS communicates directly with the physicians office if DME is missing information. E.D. will monitor ongoing compliance.

Document Submission ***Implemented***

To immediately fix the violation, DME was faxed to the physician to add height and weight. Since this violation, Resident Services Director, LPN or Resident Services Supervisor, LPN reviews all DME's prior to residents moving

141a 1-10 Medical Evaluation Information (continued)

into the community to ensure accuracy. RSD or RSS communicates directly with the physicians office if DME is missing information. E.D. will monitor ongoing compliance.

144c2 - Smoking Area Distance

1. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

Three cigarette butts were found in the mulch area adjacent to the outdoor staff smoking area. Approximately 10-15 cigarette butts were also found on the asphalt area of the staff smoking area.

Plan of Correction ***Accept***

Immediately following inspection exit interview, E.D. conducted an all staff meeting to review areas requiring immediate attention. E.D. reminded staff of the potential dangers of cigarette butts being thrown in the mulch or other flammable areas. Atria handbook was utilized to stress the importance of our smoking policy and potential corrective action or termination leading to non-compliance of this policy. "Check for cigarette butts" was also added to E.D. daily walk through process and weekend Manager on Duty responsibility list.

Plan of Correction ***Accept***

Immediately following inspection exit interview, E.D. conducted an all staff meeting to review areas requiring immediate attention. E.D. reminded staff of the potential dangers of cigarette butts being thrown in the mulch or other flammable areas. Atria handbook was utilized to stress the importance of our smoking policy and potential corrective action or termination leading to non-compliance of this policy. "Check for cigarette butts" was also added to E.D. daily walk through process and weekend Manager on Duty responsibility list.

Document Submission ***Implemented***

Immediately following inspection exit interview, E.D. conducted an all staff meeting to review areas requiring immediate attention. E.D. reminded staff of the potential dangers of cigarette butts being thrown in the mulch or other flammable areas. Atria handbook was utilized to stress the importance of our smoking policy and potential corrective action or termination leading to non-compliance of this policy. "Check for cigarette butts" was also added to E.D. daily walk through process and weekend Manager on Duty responsibility list.

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

The blood glucose reading for resident #3 taken on 8/21/21 at 5:30pm was 62 but was recorded on the MAR as 70. Also, two loose pills were found in the 2nd drawer of medication cart #3.

Plan of Correction ***Accept***

All wellness staff, including agency nurses were retrained 8/27 and 8/29 regarding the importance of proper and accurate documentation of blood sugar levels on the MAR.
Agency staff has been reduced since this violation and will also reduce the chances of this error occurring again the future. Upon finding the 2 loose pills, they were immediately discarded. Cart was re-visited and decluttered to reduce the chance of blister packs sticking together and pills coming loose. All staff were trained to inspect cart before shift change and Resident Services Supervisor will inspect on a weekly basis. Training also included proper discarding with the RX destroyer and "takeaway box

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Plan of Correction ***Accept***

All wellness staff, including agency nurses were retrained 8/27 and 8/29 regarding the importance of proper and accurate documentation of blood sugar levels on the MAR.
Agency staff has been reduced since this violation and will also reduce the chances of this error occurring again the future. Upon finding the 2 loose pills, they were immediately discarded. Cart was re-visited and decluttered to reduce the chance of blister packs sticking together and pills coming loose. All staff were trained to inspect cart before shift change and Resident Services Supervisor will inspect on a weekly basis. Training also included proper discarding with the RX destroyer and "takeaway box

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Document Submission ***Implemented***

Please see attached Staff Training Sheets addressing above POC

224a - Preadmission Screen Form

1. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

The home did not have documentation of a preadmission screening form for resident #1 who was admitted to the home on 12/21/20.

Plan of Correction ***Do Not Accept***

RSD and E.D. audited past 6 months of new admission charts to ensure pre-screen completion. All pre-screens have been completed accurately and will continue to be included with all required move in paperwork upon day of admission and added to resident chart.

Update: *11/16/2021*

Who specifically will be responsible for monitoring and ongoing compliance.
11-16-2021 MM

224a - Preadmission Screen Form *(continued)*

Plan of Correction ***Accept***

RSD and E.D. audited past 6 months of new admission charts to ensure pre-screen completion. All pre-screens have been completed accurately and will continue to be included with all required move in paperwork upon day of admission and added to resident chart. E.D. is responsible for monitoring ongoing compliance.

Document Submission ***Implemented***

RSD and E.D. audited past 6 months of new admission charts to ensure pre-screen completion. All pre-screens have been completed accurately and will continue to be included with all required move in paperwork upon day of admission and added to resident chart. E.D. is responsible for monitoring ongoing compliance.

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

The support plan for resident #1 was completed [redacted] *which is 36 days after the resident's admission date of* [redacted]

Plan of Correction ***Accept***

Resident # 1 30-day support plan was reviewed to ensure community is meeting resident's needs.

Resident Services Director audited recent move ins for the past 90 days on 9/6/21, to ensure compliance with regulation 2600 227a. Any issues found during the audit were addressed immediately.
Executive Director retrain Resident Services Director on the requirement for regulation 2600 227a on 9/5/21, to ensure compliance with state regulation.
Executive Director will be responsible for ensuring compliance with regulation 2600 227 a. Executive Director will meet with Resident Services Director weekly for the next 90-days to review new move ins and ensure compliance.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Plan of Correction ***Accept***

Resident # 1 30-day support plan was reviewed to ensure community is meeting resident's needs.

Resident Services Director audited recent move ins for the past 90 days on 9/6/21, to ensure compliance with regulation 2600 227a. Any issues found during the audit were addressed immediately.
Executive Director retrain Resident Services Director on the requirement for regulation 2600 227a on 9/5/21, to ensure compliance with state regulation.
Executive Director will be responsible for ensuring compliance with regulation 2600 227 a. Executive Director will meet with Resident Services Director weekly for the next 90-days to review new move ins and ensure compliance.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

227a - Support Plan 30 Days *(continued)*

Document Submission ***Implemented***

Please see attached Staff Training Sheets addressing above POC

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

Resident #1 has an enabler bar attached to the resident's bed. The resident's support plan dated 01/26/21 does not indicate the resident's need for an enabler bar.

Plan of Correction ***Do Not Accept***

Upon discovery of this violation, RSD made a list of all residents with known enablers on 9/5 and confirmed proper documentation in the support plan. A list of all resident apartments was divided up evenly to Directors to complete a "room check" and identify any missed enablers. E.D. spoke with therapy team and Maintenance department to make sure RSD is notified when family or residents mention bringing in a bed enabler, as often times they are the first to be notified.

Update: *11/16/2021*

Who will be responsible for monitoring and ongoing compliance? 11-16-2021 MM

Plan of Correction ***Accept***

Upon discovery of this violation, RSD made a list of all residents with known enablers on 9/5 and confirmed proper documentation in the support plan. A list of all resident apartments was divided up evenly to Directors to complete a "room check" and identify any missed enablers. E.D. spoke with therapy team and Maintenance department to make sure RSD is notified when family or residents mention bringing in a bed enabler, as often times they are the first to be notified. E.D. is responsible for monitoring ongoing compliance.

Document Submission ***Implemented***

Upon discovery of this violation, RSD made a list of all residents with known enablers on 9/5 and confirmed proper documentation in the support plan. A list of all resident apartments was divided up evenly to Directors to complete a "room check" and identify any missed enablers. E.D. spoke with therapy team and Maintenance department to make sure RSD is notified when family or residents mention bringing in a bed enabler, as often times they are the first to be notified. E.D. is responsible for monitoring ongoing compliance.

227g -Support Plan Signatures

1. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The support plan for resident #5 dated [redacted] was not signed by the assessor or by the resident.

227g -Support Plan Signatures *(continued)*

Plan of Correction ***Accept***

Support plan was later found with resident #5's signature dated [redacted]
When a new or updated support plan is created, E.D. or RSD will make immediate attempt to obtain signature. If unable to obtain, Administrative Assistant will act as back up, scan support plan to the family and follow up with a phone call to stress the importance of returning the document within 7 days. AA was trained on this process 9/8/2021.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Plan of Correction ***Accept***

Support plan was later found with resident #5's signature dated 4/29/21.
When a new or updated support plan is created, E.D. or RSD will make immediate attempt to obtain signature. If unable to obtain, Administrative Assistant will act as back up, scan support plan to the family and follow up with a phone call to stress the importance of returning the document within 7 days. AA was trained on this process 9/8/2021.

Update: *11/16/2021*

Please send/Attach proof of staff training. 11-16-2021 MM

Document Submission ***Implemented***

Please see attached Staff Training Sheets addressing above POC