Department of Human Services
Bureau of Human Service Licensing

November 15, 2021

[redacted], OWNER
[redacted]

RE: EICHER'S FAMILY HOME CARE
704 CAMP ACHIEVEMENT ROAD
NORMALVILLE, PA, 15469
LICENSE/COC#: 44674

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 10/12/2021, 10/13/2021 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: *EICHER'S FAMILY HOME CARE* **License #:** *44674* **License Expiration Date:** *03/14/2022*
Address: *704 CAMP ACHIEVEMENT ROAD, NORMALVILLE, PA 15469*
County: *FAYETTE* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/22/1997* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *43* **Waking Staff:** *32*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal* **Exit Conference Date:** *10/13/2021*

Inspection Dates and Department Representative

10/12/2021 - On-Site: [redacted]
10/13/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* **Residents Served:** *32*

Secured Dementia Care Unit

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

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older:** *32*
Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *11* **Have Physical Disability:** *2*

Inspections / Reviews

10/12/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/04/2021*

11/3/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/09/2021*

11/15/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/24/2021*

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 10/12/21, the licensing inspection summaries, dated 11/14/19 and 12/30/20, et. al., were not posted in a conspicuous and public place in the home.

On 10/12/21, a copy of 55 PA Code Chapter 2600 regulations was not posted in a conspicuous and public place in the home.

Plan of Correction **Directed**

The License Inspection Summaries were not posted in a public place at time of Inspection. Summaries of 2019-2020 were placed in PCH's front entry desk together with current license immediately following inspection on 10/12/2021. In the future the Administrator will check weekly. During her walk through inspection of PCH that both the summaries and Licenses are present and visible in front entry hall. This will be initiated the week of 10/18/2021. PCH's owner will check on compliance with this inspection.

DIRECTED: Within 72 hours of receipt of the plan of correction: A designated staff person shall post a copy of Chapter 2600 regulations in a public and conspicuous place in the home. [redacted] *11/8/21*

Completion Date: *10/18/2021*

25a - Written Contract and Review

1. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #1 was admitted to the home on [redacted] *; however, no resident-home contract was completed.*

25a - Written Contract and Review *(continued)*

Plan of Correction **Directed**

No resident contract was completed on resident #1, 10 days after her arrival at PCH. Being a temporary resident and acquaintance of owner, it was not believed that a contract was necessary. A contract was completed with " Resident" on [redacted] (see attached) in the future all individuals dwelling in PCH will have a signed contract completed within 24 hours of Admission. The PCH's administrator will review all resident charts within 72 hours after admission to make sure all admission paperwork (including contract) is complete.

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review all current resident records to ensure each resident has a resident-home contract, completed in its entirety. [redacted] 11/8/21

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure a resident-home contract is completed in its entirety within 24 hours of admission for all newly-admitted residents. The completed new admission checklist shall be kept in each resident's record. LM 11/8/21

Completion Date: *10/13/2021*

25b - Contract Signatures

1. **Requirements**

2600.

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

Description of Violation

Resident #3's resident-home contract, dated [redacted], is not signed by the resident.

Plan of Correction **Directed**

The resident home contract dated [redacted] is not signed by resident. The resident contract was mistakenly not signed, it was signed immediately following inspection on [redacted]. In the future the administrator who constructed an admission check sheet on 10/14/2021 (see attached) will begin to utilize this check sheet to make sure all admission paper work within 24 hours of admission. (DIRECTED: Within 5 days of receipt of the plan of correction: The new admission checklist shall be used for all newly-admitted residents. The completed new admission checklist shall be kept in each resident's record. [redacted] 11/8/21).

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review all current resident records to ensure each resident has a resident-home contract, completed in its entirety, and signed by all parties in accordance with 2600.25b. [redacted] 11/8/21

Completion Date: *10/14/2021*

42d - Home Rules

1. **Requirements**

2600.

42.d. A resident shall be informed of the rules of the home and given 30 days' written notice prior to the effective date of a new home rule.

42d - Home Rules *(continued)*

Description of Violation

The home's current home rules indicate, "The home does not allow permanent placement of pets"; however, on 10/2/21, a resident was admitted to the home with 2 dogs. No 30-day advance written notice was provided to the residents indicating the home changed their home rules.

Plan of Correction **Directed**

The home's current home rules indicate that dogs may visit their owners at the PCH if their vaccinations are current and they are "people friendly". The resident's dogs were at the PCH on a "visitation" basis. These dogs were being fed and permitted to sleep at the owners, [redacted] residence each day. As per contact these dogs were fully vaccinated and people friendly. No home rules were changed. No 30 day notice indicating otherwise was necessitated.

DIRECTED: Immediately upon receipt of the plan of correction: The home shall ensure no permanent placement of pets in the home in accordance with the home rules. If the home wishes to change the home rules, an advance written 30-day notice shall be provided to all residents and their designated persons prior to the home rule changing. Copy of the notification of intent to change the home rules shall be kept in each resident's record. [redacted] 11/8/21

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure each newly-admitted resident is notified of the home's current home rules and that a copy of the home's current home rules is included in the resident-home contract. The completed new admission checklist shall be kept in each resident's record. [redacted] 11/8/21

Completion Date: *10/01/2021*

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 the beds of residents #4, #6, #7, #8, #9 and #10; however, the residents were unable to demonstrate the ability to use the device.

42p - Restraints *(continued)*

Plan of Correction **Directed**

As written + then, Bed rails on the beds of residents #4,6,8,10 were removed immediately by PCH's maintenance person on 10/13/2021. After, in the future during monthly rounds the house physician will assess each resident for the need for half bed rails and their ability to utilize bedrails safely and appropriately. If a resident is assessed to be in need for half bed rails and is safe using same. The physician will write an order on the DME to this effect. In the case of residents #7, #9. Dr. Kozak has written an order on DMEs that half bed rails may be used for the purpose of turning/repositioning in bed. These DMEs that were dated 10/28/2021. In the future only residents who can safely utilize half bed rails will be permitted same after assessed by MD and order written on their DMEs. Administrator will perform ongoing assessment of these resident's mental status and their continued ability to utilize bed rails safely. If a change in status is noted it will be reported to MD and the need for bedrails reassessed. Administrator's assessment will be conducted daily. In her absence owner will conduct assessment.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: The use of bedrails or enablers will be documented in the resident's assessments and support plans and will identify an individual's ability to use the device safely for the purpose it was intended and any risk associated with their use. If any resident is unable to demonstrate the ability to operate the bedrails independently and without assistance, then the resident's physician shall immediately be notified and an alternative shall be used, such as a bed cane. [redacted] 11/15/21

Completion Date: *10/28/2021*

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

No Pennsylvania criminal background check has been completed for direct care staff person A, hired on [redacted].

Plan of Correction **Directed**

No criminal background check was completed for staff person A, hired [redacted] A complete criminal B.G check was completed [redacted] (see attached). In the future all CBC's will be completed prior to an employee's hire. A check sheet of necessary pre employment paperwork will be attached to each employee file and completed by administrator prior to each employee's date of hire. Check sheet completed 10/21/2021 (DIRECTED: The completed checklist shall be kept in each staff person's record. [redacted] 11/8/21).

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review the records of all current staff persons to ensure a Pennsylvania criminal background check is completed for each staff person. LM 11/8/21

Completion Date: *10/21/2021*

54a - Direct Care Staff

1. **Requirements**

2600.

54a - Direct Care Staff *(continued)*

54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, hired on [redacted], does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction **Directed**

See 51- As before and then administrator will construct check sheet and complete necessary paperwork prior to employment. check sheet completed 10/21/2021. (DIRECTED: The completed checklist shall be kept in each staff person's record. [redacted] 11/8/21)

DIRECTED: Within 72 hours of receipt of the plan of correction: Documentation of staff person A's high school diploma, GED or active registry status on the Pennsylvania nurse aide registry shall be obtained. Direct care staff person A shall not perform direct care duties to any residents until the documentation is obtained. The documentation shall be kept in staff person A's record. [redacted] 11/8/21

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review the records of all current direct care staff persons to ensure each direct care staff person is qualified in accordance with 2600.54a, and that copies of each direct care staff qualifications are present in each staff person's record. [redacted] 11/8/21)

Completion Date: *10/21/2021*

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 10/9/21, there were 32 residents residing in the home, including 11 residents with mobility needs, requiring a total minimum of 32.25 hours of direct care staffing during waking hours. On this day, only 32 hours of direct care staffing were provided during waking hours.

57d - Waking Hours *(continued)*

Plan of Correction **Directed**

During the days in question in regard to "insufficient staffing" the PCH owner, Connie Eicher, was on the premises but not listed on the schedule. Similarly there are days when it appears PCH is short staffed but [redacted], [redacted] *(adm) and* [redacted] *(med educator) are on premises and do full in to compliment staffing. In the future these 3 individuals will be listed on the schedule +/or will clock in and out to document sufficient staff as needed. This schedule update will begin 10/17/2021*
(see attached) [redacted]*, medication educator, will review each schedule to determine if there is sufficient staff each day ad report need to add to staff to* [redacted]*, Owner, as needed.* [redacted] *will add necessary staff +/or supervisory personnel.*

DIRECTED: Within 48 hours of receipt of the plan of correction: A designated staff person shall review the home's direct care staffing schedule daily to ensure adequate staffing in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. [redacted] *11/8/21*

Completion Date: *10/17/2021*

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

On 9/25/21, there were 28 residents in the home, including 11 residents with mobility needs. Of the 11 residents with mobility needs, 7 residents require the assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift.
On 9/28/21, there were 29 residents in the home, including 11 residents with mobility needs. Of the 11 residents with mobility needs, 7 residents require the assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift.
On 10/9/21, there were 32 residents in the home, including 11 residents with mobility needs. Of the 11 residents with mobility needs, 7 residents require the assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift.

The home's most recent fire safety inspection conducted by a fire safety expert on 9/28/21 indicates the maximum fire safe time to evacuate to the 2 fire safe areas in the home is 3 minutes, 9 seconds; however, there were only 2 staff persons present in the home on 9/25/21, 9/28/21 and 10/9/21, which is not adequate to safely evacuate all residents in the event of an emergency.

60a - Staff/Support Plan *(continued)*

Plan of Correction **Directed**

Violation states there were only 2 staff persons present in home on 09/25/2021, 09/28/2021 and 10/09/2021 which is not adequate to safely evacuate all residents in the event of an emergency.
In reviewing the schedule for the dates 09/25/2021,09/28/2021, and 10/09/2021, there were 2 direct care staff. 1 laundry and 1 kitchen staff in addition to administrative personnel [redacted] and maintenance [redacted] as Eicher's Family Home staff DO NOT USE Hoyer lifts to Transfer residents (as does Hospice Personnel), We do, therefore, believe there were sufficient staff to safely evacuate residents. In the future the schedule will reflect all induvial present within home.

DIRECTED: Within 48 hours of receipt of the plan of correction: A designated staff person shall review the home's direct care staffing schedule daily to ensure adequate staffing in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. [redacted] 11/8/21

Completion Date: *10/14/2021*

64a - Admin Training

1. **Requirements**

2600.

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

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

Description of Violation

Staff person B, the home's administrator, has not successfully completed the Department-approved orientation program.

Plan of Correction **Accept**

Administrator, [redacted], believed, having taken the Required Courses necessary, that [redacted] orientation program was completed. Having clarified this Omission with [redacted], Director of Training, administrator will complete orientation program 11/10/2021

Completion Date: *11/10/2021*

65a - FS Orientation 1st Day

1. **Requirements**

2600.

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

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

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

Description of Violation

Direct care staff person A was hired on [redacted]; however, the training document does not indicate the date staff person A received orientation on the topics specified in 2600.65a, so it is unable to be determined if the orientation was provided prior to or during the first work day.

Plan of Correction **Directed**

Prior to or during the 1st work day all D C S shall have an orientation in general fire safety and emergency preparedness. Employee # A did not have documentation reflecting this orientation although same instruction was given on 09/25/2021. It was, however, not documented by mistake. This instruction was not documented until 10/14/21. In the future administrator will document employee instruction on check sheet created 10/21/21 (see 51 + 54A). This check sheet will be affixed to all new employee folders and completed in full within 40 scheduled working hours. The owner [redacted] will review all new employee folders within 1 week of their hire.
(DIRECTED: The completed checklist shall be kept in each staff person's record. [redacted] 11/8/21)

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review the records of all current staff persons to ensure each staff person has received training on all topics specified in 2600.65a, and that the documentation of the trainings are kept in each staff person's record in accordance with 2600.65i. [redacted] 11/8/21)

Completion Date: *10/21/2021*

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:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff person A was hired on [redacted]; however, the training document does not indicate the date staff person A received orientation on the topics specified in 2600.65b, so it is unable to be determined if the orientation was provided within 40 scheduled working hours.

Plan of Correction **Directed**

As in 65A this orientation although given was not documented until 10/14/2021 due to administrator oversight. A check sheet was created which administrator will complete within 40 scheduled working hours of employment. The owner will review employee records within 1 week of their hire. (DIRECTED: The completed checklist shall be kept in each staff person's record. [redacted] 11/8/21)

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review the records of all current staff persons to ensure each staff person has received training on all topics specified in 2600.65b, and that the documentation of the trainings are kept in each staff person's record in accordance with 2600.65i. [redacted] 11/8/21)

Completion Date: *10/14/2021*

65d - Initial Direct Care Training

1. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [redacted], has not successfully completed and passed the Department-approved direct care training course and passed the competency test.

Plan of Correction **Directed**

Direct care staff A lacked documentation of having completed and passed the competency test although hired 08/27/2021. Eicher's new Administrator [redacted] was unaware of this requirement at the time of [redacted] hire. The previous Administrator who left in August did not communicate this requirement to [redacted] Employee A was asked to complete this test immediately following learning of this (add days off) 10/18/2021. (DIRECTED: A copy of staff person A's certificate shall be kept in staff person A's record. [redacted] 11/8/21). [redacted] is now aware of this requirement and has placed it on new employee check sheet. No new employee will be permitted unsupervised resident care without completion of this training in future. [redacted] will review new employee folders in future prior to employee's direct care of residents. (DIRECTED: The completed checklist shall be kept in each staff person's record. LM 11/8/21)

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review the records of all current direct care staff persons to ensure each direct care staff person has successfully completed and passed the Department-approved direct care training course and passed the competency test in accordance with 2600.65d, and that documentation of the training is kept in each staff person's record in accordance with 2600.65i. LM 11/8/21)

Completion Date: *10/18/2021*

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.

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

Description of Violation

Bilateral half-length bedrails were present at the top of resident #4's bed; however, the resident's most recent medical evaluation, dated 4/7/21, indicates "none" under the body positioning/movement section.

Bilateral half-length bedrails were present at the top of resident #6's bed; however, the resident's most recent medical evaluation, dated 3/10/21, indicates "none" under the body positioning/movement section.

Bilateral half-length bedrails were present at the top of resident #7's bed; however, the resident's most recent medical evaluation, dated 1/20/21, only indicates "as tolerated" under the body positioning/movement section.

Plan of Correction **Directed**

Bilateral half length bedrails removed 10/13/2021 from residents #4's bed as resident is unable to constructively utilize rails in care. Removed by maintenance person, Resident #6 is now deceased.
Bilateral half length bedrails used by resident #7 to reposition self and turn in bed. Because resident able to safely use bed rails and physician deems resident able to do so, order written on new DME (see attached).
Administrator will continue to assess resident's ability to safely use bed rails which are now covered with fabric sleeve and notify MD should bedrails pose threat to safety in future. This assessment will be completed daily and by owner when administrator not present.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: The use of bedrails or enablers will be documented in the resident's assessments and support plans and will identify an individual's ability to use the device safely for the purpose it was intended and any risk associated with their use. If any resident is unable to demonstrate the ability to operate the bedrails independently and without assistance, then the resident's physician shall immediately be notified and an alternative shall be used, such as a bed cane. [redacted] *11/15/21*

Completion Date: *10/13/2021*

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]

Bilateral half-length bedrails were present at the top of resident #8's bed; however, the resident's most recent medical evaluation, dated 4/7/21, only indicates "as tolerated" under the body positioning/movement section.

Bilateral half-length bedrails were present at the top of resident #9's bed; however, the resident's most recent medical evaluation, dated 6/2/21, only indicates "as tolerated" under the body positioning/movement section.

Bilateral half-length bedrails were present at the top of resident #10's bed; however, the resident's most recent medical evaluation, dated 1/6/21, only indicates "as tolerated" under the body positioning/movement section.

Plan of Correction **Directed**

Resident #2's medical evaluation was competed on 08/08/21, however MD did not sign and date DME until [redacted]*. In the future the Administrator will check all filed DME's to make sure all have been signed by the MD.*
In the future administrator will check all DME's and make sure all have been signed by MD. Same check will be completed monthly when check for pending due dates for RASP's, DME's conducted.
Bilateral half length bed rails removed from resident #8 and 10's bed as they cannot constructively use rails. Rails removed 10/13/2021 by maintenance person.
Resident 9's medical evaluation updated with physician order for bed rails as resident able to utilize rails to turn and reposition self in bed. Staff instructed to cover bed rails with sleeves for resident safety. Administrator will conduct ongoing daily assessment RE resident safety and advisability to continue use of same. Owner will assess when administrator is not present.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: The use of bedrails or enablers will be documented in the resident's assessments and support plans and will identify an individual's ability to use the device safely for the purpose it was intended and any risk associated with their use. If any resident is unable to demonstrate the ability to operate the bedrails independently and without assistance, then the resident's physician shall immediately be notified and an alternative shall be used, such as a bed cane. [redacted] *11/15/21*

DIRECTED: Within 7 calendar days of receipt of the plan of correction: A designated staff person shall review all current resident records to ensure each resident has a medical evaluation completed in its entirety, at least annually. [redacted] *11/15/21*

Completion Date: *10/13/2021*

181c - Self-administration Assessment

1. **Requirements**

2600.

181c - Self-administration Assessment *(continued)*

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 was admitted to the home on [redacted] Since admission, the resident was self-administering [redacted] own medications, to include [redacted]; however, resident #1 was not assessed by a physician, physician's assistant or certified, registered nurse practitioner until [redacted] regarding ability to self-administer medications.

Plan of Correction **Directed**

Resident #1 is an Registered nurse. [redacted] is well known to [redacted] PCP, [redacted] (also our PCH's physician). A verbal order was obtained from [redacted] staring resident may self administer all medication. This was also stated on the resident's DME dated [redacted]. In the future similar verbal orders will be obtained in writing by the administrator and placed in the resident's chart. The administrator will conduct ongoing daily assessment concerning a resident's ability to safely self administer medication and whether the resident can continue to do so. The MD will be notified if the resident's safety is in jeopardy.

DIRECTED; Immediately upon receipt of the plan of correction: No resident shall self-administer any medications unless assessed by a physician, physician's assistant or certified registered nurse practitioner. Documentation from the physician shall be kept in the resident's record, as well as indicated on the resident's most recent assessment and support plan. [redacted] 11/8/21

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review the records of all residents who are currently self-administering medications to ensure they have been assessed in accordance with 2600.181c. [redacted] 11/8/21

Completion Date: *10/15/2021*

183d - Prescription Current

1. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

183d - Prescription Current *(continued)*

Description of Violation

Resident #3 is prescribed [redacted] Place 1 drop into both eyes daily for [redacted]; however, there is no date present on the bottle indicating the date it was opened. According to the manufacture's instructions, this medication expires 28 days after opening.

Resident #3 is prescribed [redacted] -Place 1 drop into both eyes at bedtime for glaucoma; however, there is no date present on the bottle indicating the date it was opened. According to the manufacture's instructions, this medication expires 4 weeks after opening.

Resident #3 is prescribed [redacted] -Place 1 drop into both eyes twice a day for glaucoma; however, there is no date present on the bottle indicating the date it was opened. According to the manufacture's instructions, this medication expires 4 weeks after opening.

Plan of Correction **Directed**

Eye drops prescribed for resident #3 required date on each bottle when opened by med aide, but lacking same. Med aide and administrator unaware that manufacturer instructs discarding drops after 28 days. In order to clarify which drops are to be discarded after 28 days by the administrator, health direct pharmacy instructed to label all drops to which this pertains. Med aides instructed by administrator 10/14/2021 that upon receiving such bottles with time expired labels that a 28 day expiration date should be written on each bottle. In the future the Med aide accepting new eye drops should check to see if 28 day labels are needed. If the labels are missing the Administrator will contact pharmacy for additional labels. The Administrator will check all eye drops in Med room weekly to determine if any eye drops should be discarded.

DIRECTED: Within 48 hours upon receipt of the plan of correction: The undated eye drops belonging to resident #3 shall be discarded in accordance with 2600.183f. [redacted] 11/8/21

Completion Date: *10/14/2021*

184a - Labeling OTC/CAM

1. Requirements

2600.

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

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

184a - Labeling OTC/CAM *(continued)*

Description of Violation

Resident #5 is prescribed [redacted]-Use as per sliding scale 3 times daily with meals, hold if blood sugars are below 100: 100-150=15 units; 151-300=18 units; 301 or higher =24 units; however, the pharmacy label indicates Novolog-100u/ml-Inject 15 units subcutaneously 3 times daily with meals-Hold for missed meals or blood sugar below 100.

REPEAT VIOLATION: 11/14/2019

Plan of Correction **Directed**

The pharmacy label dose not state "hold for missed meals". Eicher's understood at time of inspection that our error was in the transcription of the numbers of the sliding scale written by pharmacy (IE 100-150= 15 units, 150-300=18 units when should of been 100-150 and 151-300) Administrator contacted pharmacy and label was corrected 10/14/21. In the future Med aid and administrator will check pharmacy written labels for sliding scales more carefully and when medication is delivered will contact pharmacy if incorrect for corrected labels. (see attached)

DIRECTED: Within 5 calendar days of receipt of the plan of correction, then monthly thereafter: A designated staff person shall review the pharmacy labels of all resident medications to ensure accuracy in accordance with current prescribers' orders. [redacted] 11/8/21

DIRECTED: Within 7 calendar days of receipt of the plan of correction: All staff persons qualified to administer medications shall be reeducated on the home's procedures for updating pharmacy labels as new medication orders are received from the prescriber. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 11/8/21

Completion Date: *10/14/2021*

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

On 10/6/21 at 4:30 pm, resident #5's blood glucose was 170; however, a blood glucose reading of 189 was documented on the resident's October 2021 blood sugar log.

On 10/9/21 at 4:06 pm, resident #5's blood glucose was 199; however, a blood glucose reading of 194 was documented on the resident's October 2021 blood sugar log.

On 10/10/21 at 4:28 pm, resident #5's blood glucose was 240; however, a blood glucose reading of 241 was documented on the resident's October 2021 blood sugar log.

185a - Implement Storage Procedures *(continued)*

Plan of Correction **Accept**

Blood glucose levels read on the machine and documented on blood sugar log differed. Medication aide performing accuchecks will bring blood sugar log with her when performing blood glucose readings. Med aides instructed by Administrator 10/15/2021 to document readings in log prior to removing accucheck strip from machine. All med aides instructed are importance of accurate blood glucose readings in administration of proper insulin coverage when met with individually 10/14 and 10/15. Administrator will check accuracy of blood glucose log every 2 weeks. (see attached)

Completion Date: *10/15/2021*

187a - Medication Record

1. **Requirements**

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #3 is prescribed [redacted]-Take 1 tablet by mouth daily; however, the resident's October 2021 medication administration record (MAR) indicates L[redacted] Take 1 tablet by mouth daily.

Resident #4 is prescribed [redacted]-Take 1 tablet by mouth twice a day; however, there is no diagnosis or purpose indicated on the resident's October 2021 MAR for this medication.

Resident #5 is prescribed [redacted]Use as per sliding scale 3 times daily with meals, hold if blood sugars are below 100: 100-150=15 units; 151-300=18 units; 301 or higher =24 units; however, the resident's entire prescribed sliding scale is not indicated on the resident's October 2021 MAR.

REPEAT VIOLATION: 12/30/2020 et. al.

187a - Medication Record *(continued)*

Plan of Correction **Directed**

Resident #3 taken to 2 separate physician by daughter. One MD wrote a rx for 125mcg and the other MD wrote a RX for 112 mcg. MAR continued to reflect 112 mcg when 125 mcg delivered by pharmacy. Med aid receiving Meds did not recognize discrepancy or have knowledge of 2 different physician orders written that day. Discrepancy noted by Inspector 10/13/2021. Administrator clarified nature of discrepancy (2 MD involvement). With resident's daughter 10/15/2021 administrator called resident's PCP who rewrote RX and clarified dosage. 10/15/2021. In the future administrator/ medication trainer will clarify new orders if any following MD appointments and transcribe any changes on MAR. (DIRECTED: Within 48 hours of receipt of the plan of correction: Resident #2's MAR shall be updated to reflect the most recent prescriber's order. [redacted] 11/8/21)
Medication, [redacted] transcribe on resident #4 medication sheet without a diagnosis/purpose indicated. Medication sheet was corrected and diagnosis book disorder added as diagnosis on 10/14/2021 (see attached). In the future medication trainer will write corresponding diagnosis when transcribing medications on medication sheet.
Resident #5's Novolog sliding scale was not written in entirety on the resident's MAR. Administrator notified pharmacy and requested label indicating parameters to affix to MAR on 10/15/2021 (see attached). In the future the sliding scale will be written in it's entirety both on the MAR and Diabetic log book. The Med aid will report any lack of sliding scale to either book to the Administrator immediately if found in the future. (DIRECTED: Within 48 hours of receipt of the plan of correction: Resident #5's MAR shall be updated to reflect the most recent prescriber's order. [redacted] 11/8/21)

DIRECTED: Within 5 calendar days of receipt of the plan of correction, then monthly thereafter: A designated staff person shall review all current resident MAR's to ensure accuracy and completeness in accordance with prescribers' orders and 2600.187a. Documentation of the audits shall be kept. [redacted] 11/8/21

DIRECTED: Within 7 calendar days of receipt of the plan of correction: All staff persons qualified to administer medications shall be reeducated on the home's procedures for updating resident MAR's as new medication orders are received from the prescriber. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 11/8/21

Completion Date: *10/15/2021*

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

Resident #1 was admitted to the home on [redacted]; however, no preadmission screening was completed.

224a - Preadmission Screen Form *(continued)*

Plan of Correction **Directed**

No preadmission screening was completed for resident #1, it was not the owner's intent to admit this individual to the Personal care home. "Resident" was thought to stay only on an emergent and temporary basis. The preadmission screening was completed on 10/15/2021 (see attached). In the future the administrator will complete the screening prior to their admission whether admission temporary or permanent.

DIRECTED: Within 10 calendar days of receipt of the plan of correction: A designated staff person shall review all current resident records to ensure each resident has a preadmission screening, completed in its entirety. [redacted] *11/8/21*

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure a preadmission screening is completed in its entirety within 30 days prior of admission for all newly-admitted residents. The completed new admission checklist shall be kept in each resident's record. [redacted] *11/8/21*

Completion Date: *10/15/2021*

225a - Assessment 15 Days

1. **Requirements**

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #4 requires the use of a Hoyer lift with 2 staff persons to transfer in/out of bed/chair; however, the resident's assessment, dated [redacted] *indicates the resident requires some physical assistance with transferring.*

Resident #7 requires the use of a Hoyer lift with 2 staff persons to transfer in/out of bed/chair; however, the resident's assessment, dated [redacted]*, indicates the resident requires some physical assistance with transferring.*

225a - Assessment 15 Days *(continued)*

Plan of Correction **Directed**

Although Hospice staff utilizes the Hoyer life to transfer residents #4 and 7, Eicher's staff safely transfers both residents with the assist of 2 staff. In the future both methods of transfer will written by administrator on the resident's RASP. (see attached)
The Administrator will perform ongoing daily assessment on current staff modes of transfer and determine PT safely. If same mode become unsafe the resident plan of care will be altered to ensure safety immediately.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: The assessments for residents #4 and #7 shall be updated to include transferring assistance. The updated assessments shall be kept in the resident's records. LM 11/8/21

DIRECTED: Within 5 calendar 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. Documentation of the system shall be kept. [redacted] 11/8/21

Completion Date: *10/14/2021*

226a - Mobility Assessment

1. **Requirements**

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #4's most recent assessment, dated [redacted], indicates the resident is moderately immobile; however, the resident requires the use of a Hoyer lift with the assistance of 2 staff persons to transfer in/out of bed/chair;

Resident #7's most recent assessment, dated [redacted], indicates the resident is moderately immobile; however, the resident requires the use of a Hoyer lift with the assistance of 2 staff persons to transfer in/out of bed/chair.

Plan of Correction **Directed**

Both residents #4 and #7 are moderately mobile as they can be and are safely transferred out of bed by 2 staff persons employed by Eicher's. Both residents are hospice patients and the Hoyer life is used only to transfer them by hospice staff when they are present in the home. (see previous Rasp attachment)
The Administrator will write both methods of transfer and by whom on RASP. Written with ongoing assessment daily concerning each mode of transfer and it's safety.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: Residents #4 and #7's assessment shall be updated to indicate total immobile and the need for 2 staff persons to transfer in/out of bed/chair. [redacted] 11/8/21

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. Documentation of the system shall be kept. [redacted] 11/8/21

Completion Date: *10/15/2021*

227d - Support Plan Medical/Dental

1. Requirements

2600.

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

Description of Violation

Bilateral half-length bedrails were present at the top of resident #4'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. Also, the resident's support plan does not indicate the need to transfer in/out of bed with the use of a Hoyer lift and the assistance of 2 staff persons.

Bilateral half-length bedrails were present at the top of resident #6'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 #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. Also, the resident's support plan does not indicate the need to transfer in/out of bed with the use of a Hoyer lift and the assistance of 2 staff persons.

Bilateral half-length bedrails were present at the top of resident #8'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. Also, the resident's support plan does not indicate the need to transfer in/out of bed with the use of a Hoyer lift and the assistance of 2 staff persons.

Bilateral half-length bedrails were present at the top of resident #9'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. Also, the resident's support plan does not indicate the need to transfer in/out of bed with the use of a Hoyer lift and the assistance of 2 staff persons.

Bilateral half-length bedrails were present at the top of resident #10'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. Also, the resident's support plan does not indicate the need to transfer in/out of bed with the use of a Hoyer lift and the assistance of 2 staff persons.

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

Plan of Correction **Directed**

Support plans of Resident's #4,6,7,8,9 and 10 did not address the need for half bedrails nor did they address the need to transfer residents #4,7,8,9 an 10 y use of Hoyer life. Although half bed rails were being used as a means to prevent resident fall it is now understood that bedrails' can only be utilized when the resident can knowingly use these to sit/stand or reposition/turn self in bed and to safely use bedrails. Half bedrails were removed from the beds of resident's 4,8 and 10. Alternative means to prevent/ minimize falls are being investigated by owner. I.E. fall mats, bed alarms, ect. These alternate means will be obtained within 2 weeks. An interim plan of increased staff supervision of every 30 min checks during time resident in bed has been instituted. Resident #7,9 who do knowingly use half bed rails to turn and reposition themselves in bed, have had their support plans updated (see attached) reflecting addition of physician order to DME for bedrails. Also the need to cover bedrails with a padded sleeve for PT safety was addressed in their plans. As in 222a Hoyer lift are used for the transfer of residents $4,7,8,9 and 10 only by hospice staff. Eicher's staff safely transfers these residents with the assistance of 2 staff. Hospice mode of transfer was added to each resident's RASPs.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: The use of bedrails or enablers will be documented in the resident's assessments and support plans and will identify an individual's ability to use the device safely for the purpose it was intended and any risk associated with their use. If any resident is unable to demonstrate the ability to operate the bedrails independently and without assistance, then the resident's physician shall immediately be notified and an alternative shall be used, such as a bed cane. [redacted] *11/15/21*

Completion Date: *10/15/2021*

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

Resident #4's support plan, dated [redacted] *is not signed by the assessor or the resident. The resident's support plan does not indicate if the resident participated in the development of the support plan, refused to sign the support plan or was unable to sign the support plan.*

Plan of Correction **Directed**

Administrator, [redacted]*, who completed assessment is no longer employed at Eicher's and is unable to sign. Assessment reviewed by* [redacted] *who agrees with assessment and has Co signed indicating same . Resident (see attached) signed plan on 10/15/2021. Administrator will check the completion of all RASPS due each month on the last working day of that month and correct all omissions.*

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review the support plans of all current residents to ensure all individuals who participated in the development of the support plan have signed the support plan. If the resident did not sign the support plan, a notation shall be present indicating the resident declined to participate in the development of the support plan, refused to sign the support plan or was unable to sign the support plan. [redacted] *11/8/21*

Completion Date: *10/15/2021*