DEPARTMENT OF HUMAN SERVICES
RECOMMENDATION FOR CERTIFICATE OF COMPLIANCE

REGION	COUNTY
S ☐ N ☐ C ☐ W ☒	ALLEGHENY
NAME OF LEGAL ENTITY: MOS GRACE MGT LLC	TELEPHONE NO. OF LEGAL ENTITY: 973-986-9629
MAILING ADDRESS OF LEGAL ENTITY: 118 PARKER ROAD CHESTER, NJ 7930	
NAME OF AGENCY/FACILITY: GRACE MANOR AT NORTH PARK	TELEPHONE NO. OF FACILITY: 412-367-4722
ADDRESS OF FACILITY: 9565 BABCOCK BOULEVARD ALLISON PARK PA 15101	

TYPE OF CERTIFICATE	EFFECTIVE DATE (CURRENT CERT.)	IF PRIVATE
☐ New ☒ Renewal ☐ Revision	2/3/21 to 2/3/22	☒ Profit ☐ Non-Profit

CERTIFICATE NUMBER	LICENSED CAPACITY	CURRENT CENSUS	TYPE OF CONTROL
45085	67	39	☐ Public ☒ Private

TYPE OF FACILITY AND TYPE OF SERVICE PROVIDED:

REGULATION CHAPTER AND SERVICE TYPE	POPULATION SERVED (INDICATE TYPE: Child, Adult, Geriatric, etc.) (PCH-#SSI,#6o+,#MH,#ID,#MN)
2600 regulations Personal Care Home and SCDU -3rd floor	#SSI:0; #60>:38; #MH:1; #ID;0; #PD:0; #MN:28; #Hospice:7; SCDU:17

DATES OF INSPECTION	BEO APPROVAL DATE
10/12/21, 10/13/21 and 10/14/21	

RECOMMENDATIONS

☒ CERTIFICATE RECOMMENDED	TYPE: ☒ Regular ☐ Provisional	IF PROVISIONAL: ☐ First ☐ Second ☐ Third ☐ Fourth
	SCORE	PERIOD: FROM TO

☐ NEGATIVE SANCTION	REASON: ☐ Denial ☐ Non-Renewal ☐ Revocation ☐ Voluntary Closure ☐ Other	EFFECTIVE DATE OF ACTION

BASIS FOR RECOMMENDATION

CERTIFICATE OF OCCUPANCY ☒ YES ☐ NO	DATE: 11/18/2010	ISSUING AUTHORITY/TYPE: Town of McCandless I-2

LIST ANY RESTRICTIONS TO CERTIFICATE OF COMPLIANCE (If required by program office)

Secure Care Dementia Care Unit 55 Pa Code 2600.231-239 - Capacity 25

REVISION OF EXISTING CERTIFICATE OF COMPLIANCE

ITEM (address, capacity, legal entity, other)	CURRENT	NEW	EFFECTIVE DATE OF CHANGE

SIGNATURE/DATE - STAFF MAKING RECOMMENDATION	SIGNATURE/DATE - PROGRAM OFFICE APPROVAL
	12/27/21

Department of Human Services
Bureau of Human Service Licensing

December 27, 2021

ALEXIS MARTINI, VICE PRESIDENT OF OPERATIONS
MOS GRACE MGT LLC
118 PARKER ROAD
CHESTER, NJ, 7930

RE: GRACE MANOR AT NORTH PARK
9565 BABCOCK BOULEVARD
ALLISON PARK, PA, 15101
LICENSE/COC#: 45085

Dear Ms. Alexis Martini,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/12/2021, 10/12/2021, 10/12/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Jon Kimberland

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *GRACE MANOR AT NORTH PARK* **License #**: *45085* **License Expiration**: *02/03/2022*

Address: *9565 BABCOCK BOULEVARD, ALLISON PARK, PA 15101*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: *Cathy Himes* **Phone**: *412-367-4722* **Email**: *cathy@gracemanornorthpark.com*

Legal Entity

Name: *MOS GRACE MGT LLC*

Address: *118 PARKER ROAD, CHESTER, NJ, 7930*

Phone: *4123674722* **Email**: *cathy@gracemanornorthpark.com*

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/18/2010* **Issued By**: *Town of McCandles*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *67* **Waking Staff**: *50*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/13/2021*

Inspection Dates and Department Representative

10/12/2021 - On-Site: Karen Georgoulis

10/12/2021 - On-Site: Karen Georgoulis

10/12/2021 - On-Site: Karen Georgoulis

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served**: *39*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd floor* **Capacity**: *25* **Residents Served**: *17*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *38*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *28*

Have Physical Disability: *0*

Inspections / Reviews

10/12/2021 - Full

Lead Inspector: *Karen Georgoulis* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/17/2021*

Inspection Dates and Department Representative *(continued)*

12/20/2021 - POC Submission

Reviewer: *Jon Kimberland* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/22/2021*

12/23/2021 - POC Submission

Reviewer: *Jon Kimberland* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/28/2021*

12/27/2021 - Document Submission

Reviewer: *Jon Kimberland* **Follow-Up Type**: *Not Required*

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, between the hours of 9:00 a.m. and 5:00 p.m., a copy of 55 Pa. Code Chapter 2600 was not posted in the home.

Plan of Correction ***Accept***

55Pa. 2600 was at the front desk and not on the counter. This has been moved to the counter at the time of inspection. This will be audited by Assistant Executive Director/Designee weekly for 3-months to ensure compliance.
Attachment: 1-2
Completion Date: *12/08/2021*

Document Submission ***Implemented***

See attached
Completion Date: *12/27/2021*

88a - Surfaces

1. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 10/12/21, the push lock on the interior side of #314's bedroom door was removed, leaving a hole in the doorknob, posing a hazard in memory care east wing.

On 10/12/21, the floor between fires doors by bedroom #207 of the second-floor hallway is deteriorating, causing the vinyl flooring on top to be bumpy and rutted. The right corner is missing from the end of a vinyl plank, measuring approximately 2" by 1 ½", that goes down the middle of the hallway.

Plan of Correction

Hole has been secured and all knobs on the floor has been audit and fixed if needed. No concerns are identified and an audit will be completed every month for 3 months and than randomly to ensure continuous compliance.
Attachment 3-4

the floor was fixed at the time of inspection. Floor will be monitored monthly for 3-months for compliance by the Director of Environmental Services to ensure that the repair job is satisfactory
Attachment : 5-6
Completion Date: *12/08/2021*

Plan of Correction ***Accept***

Re-education is being done

Attachment: 1A

Completion Date: *12/21/2021*

88a - Surfaces *(continued)*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

100a - Exterior - Free of Hazards

1. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The concrete on the ramp at the right of exterior front entrance has several areas where the concrete is deteriorating and crumbling across the entire width of the ramp, posing a trip/fall hazard. To include, an area measuring approximately 5' by 1 ½" by 1 ½" deep one measuring approximately 5' by 6 1/2" and one measuring approximately 5' by 1 ½".

Plan of Correction ***Accept***

Outdoor mats were put down at the time of inspection to ensure a level and smooth ramp. Ramp will have new cement in the spring and will be monitored for breakage.
Attachment: 7
Completion Date: *12/08/2021*

Document Submission ***Implemented***

See attached
Completion Date: *12/27/2021*

101j2 - Bedroom Chairs

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

On 10/12/21, there are two residents occupying bedroom #201. However, there is only one chair in the room. Resident #1 does not have a chair.

Plan of Correction

Resident has been educated on the regulation and still has refused the chair in her room. Options have been given to her and she still refuses the chair. Resident has signed a paper with her wishes and care plan has been updated to reflect her wishes.

Attachment: 8-9
Completion Date: *12/14/2021*

Plan of Correction ***Accept***

Chair was put in the residents closet and resident has been educated on the location of the chair if she wishes to use if for her or any guest.

Attachment: 2A
Completion Date: *12/21/2021*

101j2 - Bedroom Chairs *(continued)*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

101j3 - Bed/Linens/Pillows/Blankets

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 10/12/21, the pillow on resident #1's bed did not have a pillow case.

Plan of Correction

Pillow case was put on at the time of inspection. Rooms will be audited weekly for 3-months to ensure all rooms are compliant by the Director of Environmental Services. Random checks will be performed periodically to ensure on-going compliance.
Attachment: 10

Completion Date: *12/15/2021*

101j3 - Bed/Linens/Pillows/Blankets *(continued)*

Plan of Correction ***Accept***

Staff re-education is being completed

Attachment: 3A

Completion Date: *12/21/2021*

Document Submission ***Implemented***

See attached

Completion Date: *12/27/2021*

102i - Soap Dispenser

1. Requirements

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

Description of Violation

On 10/12/21, there was an unlabeled, used white bar of soap on the left side of the sink counter in the shared private bathroom in bedroom #201.

Plan of Correction

Bart soap was thrown away at the time of inspection. Residents have all been re-educated in regards to the regulations pertaining to soap in a shared room.
Bathrooms will be audited weekly for 3-months to ensure no bar soap is in resident bathrooms. Audits will be performed randomly to ensure on-going compliance.

Attachment: 11-12

Completion Date: *12/15/2021*

Plan of Correction ***Accept***

RE-education is being done

Attachment: 4A

Completion Date: *12/21/2021*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

103g - Storing Food

1. Requirements

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

Description of Violation

On 10/21/21, at approximately 11:40 a.m., there was the following open and unsealed food items in the kitchen pantry, to include:

• A 49.8 oz. bag Culinary Secrets Traditional Stuffing Mix.

103g - Storing Food (continued)

• A 16 oz. bag Kettle Cooked potato chips, approximately ¾'s full.

On 10/12/21, at approximately 11:53 a.m. there was a 5lb. package of white American Cheese open and unsealed in the refrigerator. There were two stacks of 40 count each remaining in package.

Plan of Correction

A clip was put on the bags at the time of inspection. Storage department will be audited weekly for 3-months to ensure all food is stored properly by the Assistant Executive Director. Random audits will be performed on-going to ensure compliance.

Attachment: 13
Completion Date: *12/15/2021*

Plan of Correction ***Accept***

Re-education is being done
Attachment: 5A
Completion Date: *12/21/2021*

Document Submission ***Implemented***

See Attached
Completion Date: *12/27/2021*

141b1 - Annual Medical Evaluation

1. Requirements

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

Description of Violation

The medical evaluation for resident #2, dated 9/8/21, does not include the height and immunization status. These sections are blank. Section (2). Medical Diagnoses, Physical/Mental and (3) Medical Information Pertinent to Diagnosis and Treatment indicate see attached. However, nothing was attached. The second page, Diagnoses Addendum, and medication addendum indicates "See Attached". However, nothing was attached, and Section (4) Needs Addendum is blank.

Plan of Correction

All medical evaluations were reviewed and no other errors identified house-wide. Director of Wellness or designee will audit all medical evaluations for 3-months for compliance. Any new/sig. changes/annual medical evaluations will be reviewed by both the Director of Wellness and Assistant Executive Director for compliance. They will log the medical evaluations and initial for compliance going-forward.

Attachment: 14

Completion Date: *12/13/2021*

Plan of Correction ***Accept***

Resident passed away
Completion Date: *12/20/2021*

141b1 - Annual Medical Evaluation *(continued)*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

162c - Menus Posted

1. Requirements

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

Description of Violation

On 10/12/21, at approximately 11:20 a.m., the menus posted in the dining room of the memory care unit indicate week 1, week 2, and week 3. However, there are no dates to identify the weeks current menu.

Plan of Correction ***Accept***

New menus were hung at the time of inspection with a menu calendar to show what menu we are on at all times. Menus will be audited for 3-months to ensure they are posted properly and in compliance by the Director of Environmental Services. Than they will be audited randomly for on-going compliance.

Attachment: 15-16

Completion Date: *12/08/2021*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

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.

Description of Violation

On 10/13/21, resident #1's prescribed Lorazepam tablet 0.5mg take one tablet three times a day, as needed for anxiety. The medication was discontinued on 8/26/21; however, the medication was still stored in the medication cart.

Plan of Correction

This was removed at the time of inspection. All medications carts will be audited weekly for 2-months, than monthly on-going to ensure compliance by the Director of Wellness.

Attachment: 17

Completion Date: *12/08/2021*

Plan of Correction ***Accept***

Re-education for staff is being done

Attachment: 6A

Completion Date: *12/21/2021*

183d - Prescription Current *(continued)*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

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:

Description of Violation

On 10/13/21, resident #1's October medication administration record,(MAR) indicates the resident is prescribed Albuterol AER HFA- Inhale two puffs every 6 hours as needed and an order Albuterol AER HFA – Inhale two puffs twice a day (9:00 a.m. and 9:00 p.m.). However, the only pharmacy label on the bag indicates Albuterol AER HFA-Inhale two puffs every 6 hours as needed.

Plan of Correction

Label was changed at the time of inspection. Med Carts will be audited weekly for 2-months then monthly on-going to ensure compliance by the Director of Wellness.

Attachment: 18-19

Completion Date: *12/08/2021*

Plan of Correction ***Accept***

Re-education for staff is being completed.

Attachment: 7A

Completion Date: *12/21/2021*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

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 10/13/21, resident #1 is prescribed blood glucose checks one time a day at 9:00 a.m. The October 2021 MAR indicates the resident #1's glucometer (Prodigy Pocket glucometer, serial #50302BU0262158) did not have "coding strips" or "batteries needed changed" and could not test the residents blood sugar levels. However, the home's "extra glucometer" (One Touch Verio Flex serial # (21) ZNPGQ1W0) was used to test blood sugar levels of resident #1. However, the blood glucose readings are either not documented in the October 2021MAR or are not recorded on the glucometer, as follows:
• 10/7/2021 at 9:00 a.m., the October 2021 MAR no blood glucose reading. Exception: "Prodigy Pkt No coding strips Other". However, the Prodigy glucometer indicated a blood sugar reading of 112 @ 7:28a.m.
• 10/6/21 at 9:00 a.m., the October 2021 MAR indicates a blood glucose reading of 122. However, Exception: "Prodigy

185a - Implement Storage Procedures (continued)

Pkt, no coding strips, machine needs battery, used emergency machine from office". The "extra glucometer" indicated a reading of 122.
• 10/5/21 at 9:00 a.m., the October 2021, MAR indicates a blood glucose reading of 113. Exception "no coding strips, machine needs battery, used spare from office." However, the blood glucose reading was not indicated on either glucometer.
• 10/3/21 at 9:00 a.m., the October 2021 MAR indicated a blood glucose reading of 121. However, the blood glucose reading of 121 was not on either glucometer.

On 10/14/21, resident #3's October 2021 MAR includes the following medications; however, the medications were not available in the home on 10/1/21, 10/2/21, 10/3/21 and 10/4/21, to include:
• Omeprazole cap 20mg – take one capsule by mouth every day (9:00 a.m.)

Resident #3 is prescribed blood glucose readings three times a day (7:30a.m., 11:30 a.m., and 4:30p.m.). However, the blood glucose readings were incorrectly documented on the October 2021 MAR or were not indicated on the glucometer, to include the following dates/times:
Date Time MAR Glucometer
10/11 @ 11:30 a.m. 286 no reading
10/10 @ 11:30 a.m. 224 no reading
10/09 @ 4:30 a.m. 289 no reading
10/05 @ 4:30 a.m. 223 no reading
10/03 @ 4:30 a.m. 330 229
10/03 @ 11:30 a.m. 345 no reading
10/02 @ 4:30 a.m. 342 no reading
10/02 @ 11:30 a.m. 320 420
10/02 @ 7:30 a.m. 249 404

On 10/13/21, resident #4's glucometer was not calibrated to the correct time indicating 10/13 at 2:42; however, the actual date/time was 10/13/21 at 3:42 p.m.
Resident #4 is prescribed blood glucose monitoring every Monday and Thursday once a day (9:00 a.m.) However, on 10/13/21, the following blood glucose readings were either incorrectly documented in the October 2021 MAR or not indicated on the resident's glucometer, to include:
Date & Time MAR Glucometer
10/4/21 @ 8:48 a.m. 126 no reading
9/30/21 @ 11:03 a.m. 217 no reading

Plan of Correction

Resident 1- "Extra Glucometer" was discarded at the time of inspection. Blood glucose readings/administration log was put in place immediately to ensure accuracy and is monitored weekly going-on by Assistant Executive Director.

Resident 3- Resident returned to facility on 9/30 around 6pm. Orders were sent to pharmacy on 9/30 for medication that didn't come with resident from previous facility and delivered on 10/1 around 3pm. Medication was documented in route on the 10/1 and was administered on 10/2, 10/3 and 10/4 according to MAR.

Resident 3- Blood glucose readings/administration log was put in place immediately to ensure accuracy and is

185a - Implement Storage Procedures (continued)

Resident 4- Glucometer was not changed for the time change.

Resident 4- Blood glucose readings/administration log was put in place immediately to ensure accuracy and is monitored weekly going-on by Assistant Executive Director.

Attachment: 20-23
Completion Date: *12/15/2021*

Plan of Correction ***Accept***

Re-education is being completed for staff

Attachment: 8A
Completion Date: *12/21/2021*

Document Submission ***Implemented***

See Attached
Completion Date: *12/27/2021*

187b - Date/Time of Medication Admin.

1. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 10/13/21, the October 2021 MAR for resident #1 was not initialed by the staff person who administered the blood glucose checks on 10/5/21 and 10/7/21at 9:00 a.

On 10/14/21, the October 2021 MAR for resident #3's was signed off by staff person as being administered; however, the medications were not available in the home, to include:
• ProSource Liquid No Carb and Polyethene Glycol Powder 3350 NF on 10/3/21 at 9:00 a.m.
• Clobetasol Cream 0.05% on 10/1/21 and 10/2/21 at 9:00 p.m., 10/3/21 at 9:00 a.m. and 9:00 p.m. and 10/4/21 at 9:00 p.m.
• ~~Omeprazole cap 20mg on 10/2/21, 10/3/21 and 10/4/21 at 9:00 a.m.~~ VIOLATION WITHDRAWN 12/27/21 JK

Plan of Correction

Resident 1- Blood glucose readings/administration log was put in place immediately to ensure accuracy and is monitored weekly going-on by Assistant Executive Director.

Resident 3-
Omeprazole cap 20mg Medication was documented in route on the 10/1 and was administered on 10/2, 10/3 and 10/4 according to MAR.

ProSource Liquid No Carb, Polyethene Glycol Powder 3350 NF and Clobetasol Cream 0.5%. This was a documentation error and all staff has been re-educated on ensuring that all medication that is given is marked off and all medication that isn't given is documented properly.

Attachment: 24-27
Completion Date: *12/15/2021*

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction ***Accept***

All medications records will be reviewed weekly to ensure all documentation is correct and all medication was passed as prescribed.

Attachment: 9A

Completion Date: *12/21/2021*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #1 is prescribed blood glucose readings to be done one time daily (9:00 a.m.) However, on 10/7/21, resident # did not have a blood glucose check as prescribed.

Resident #2 is prescribed Scopolamine Dis 1mg/3-day patch. Apply one patch topically every 72 hours. The October 2021 MAR indicates the patch was applied on 10/10/21 at 9:00 a.m. behind the residents left ear. The patch was not changed until 10/13/21, (4 days/ 96 hours after) applied on 10/10/21. On 10/12/21, at 9:32 a.m., the October MAR indicated "no time to change."

On 10/13/21, the following prescribed medications for resident #3, were not administered as prescribed due to not being available in the home from 10/1/21 to 10/4/21, to include:
• ProSource Liquid No Carb – take two tablespoons (30ml) by mouth every day (9:00am).
• Polyethene Glycol Powder 3350 NF-dissolve one capful (17gm) in 8oz. glass of water and take by mouth daily (9:00 a.m.)
• Clobetasol Cream 0.05% apply twice a day (9:00 a.m. and 9:00 p.m.) to arms and legs.
• Omeprazole cap 20mg – take one capsule by mouth every day (9:00 a.m.) VIOLANTION WITHDRAWN 12/27/21 JK

Resident #4 is prescribed blood glucose monitoring one time a day every Monday and Thursday. However, the October 2021, MAR Exception indicates on 10/7/21 at 9:38 a.m., that the staff "Physically unable to take." The resident did not have the blood glucose level taken as prescribed.

Plan of Correction

Resident 1- Blood glucose readings/administration log was put in place immediately to ensure accuracy and is monitored weekly going-on by Assistant Executive Director. Order was D/C at time of inspection

Resident 2- Patch was put on at 9:38m am on 10/10 and taken off at 8:31 am on 10/13 and new patch applied. This is according to the order (72-hours) and documented on the MAR

Resident 3-
Omeprazole cap 20mg Medication was documented in route on the 10/1 and was administered on 10/2, 10/3 and

187d - Follow Prescriber's Orders (continued)

~~10/4 according to MAR.~~ VIOLATION WITHDRAWN 12/27/21 JK

ProSource Liquid No Carb, Polyethene Glycol Powder 3350 NF and Clobetasol Cream 0.5%. This was a documentation error and all staff has been re-educated on ensuring that all medication that is given is marked off and all medication that isn't given is documented properly.

Resident 4- Blood glucose readings/administration log was put in place immediately to ensure accuracy and is monitored weekly going-on by Assistant Executive Director. Order was D-C at time of inspection

Attachment: 28-34

Completion Date: *12/15/2021*

Plan of Correction ***Accept***

Doctor and family was notified at time of inspection. Doctor D/C'd blood sugar checks for resident #1 and #4 at the time of inspection.
Director of Wellness filed an Incident report with the department on 12/21/2021 as part of the plan of correction.

Attachment: 10A and 11A

Completion Date: *12/21/2021*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

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

Resident #2 was assessed as a total immobile for ambulation and mobility needs. However, the residents support plan dated 9/13/21, indicated the mobility needs and plan to meet the resident's mobility needs as "resident requires moderate physical or oral assist to evacuate in an emergency. Staff will provide oral and/or verbal assistance with evacuations in an emergency." However, the resident is non-weight bearing, requires an assist of two staff persons for all transfers, requiring the use of a wheelchair and unable to propel independently, requiring staff assistance to move through the facility, therefore would not be able to evacuate in the event of an emergency.

Plan of Correction

This was corrected at time of inspection. All medical evaluations were reviewed and no other errors identified house-wide. Director of Wellness or designee will audit all medical evaluations for 3-months for compliance. Any new/sig. changes/annual medical evaluations will be reviewed by both the Director of Wellness and Assistant Executive Director for compliance. They will log the medical evaluations and initial for compliance going-forward.

227d - Support Plan Medical/Dental (continued)

Attachment: 35

Completion Date: *12/15/2021*

Plan of Correction ***Accept***

Resident passed away

Completion Date: *12/20/2021*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

42s - Privacy

1. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 10/12/21, at approximately 10:53 a.m., there is no lock on the door of the single use common bathroom with shower to afford privacy, in the family room on the third-floor memory care east wing.

REPEAT VIOLATION 7/6/21

Plan of Correction ***Accept***

This was fixed at the time of inspection. We will audit all locks on the doors on the third floor weekly and report any doors that are not working properly.

Attachment: 36 -37

Completion Date: *12/15/2021*

Document Submission ***Implemented***

See Attached

Completion Date: *12/27/2021*

91 - Telephone Numbers

1. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 10/12/21, the cordless telephone on the third-floor med room in memory care did not have the emergency phone numbers posted on or near the phone itself or the base.

REPEAT VIOLATION 10/5/2020

Plan of Correction ***Accept***

Numbers were posted immediately and residents were educated on the importance of having the numbers posted. Audit will be completed on all phones monthly for 3-months and than randomly to ensure compliance by the

91 - Telephone Numbers (continued)

Director of Environmental Services

Attachment: 38-39
Completion Date: *12/15/2021*

Document Submission ***Implemented***

See Attached
Completion Date: *12/27/2021*

95 - Furniture and Equipment

1. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 10/12/21, the towel rack has been broken off the wall to the right of the door in the private bathroom in bedroom #314, in memory care east wing.

REPEAT VIOLATION 10/5/20

Plan of Correction ***Accept***

This was replaced at the time of inspection. Director of Environmental Services will audit all bathrooms for 3-months to ensure all towel racks and toilet paper dispensers to ensure they are up, Names are located on towel racks and all in proper working conditions. Audit will than be completed randomly to ensure compliance.

Attachment: 40
Completion Date: *12/08/2021*

Document Submission ***Implemented***

See Attached
Completion Date: *12/27/2021*