Department of Human Services
Bureau of Human Service Licensing

April 12, 2022

[redacted], CONSULTANT

RE: MAPLE SHADE MEADOWS SENIOR LIVING
50 EAST LOCUST STREET
NESQUEHONING, PA, 18240
LICENSE/COC#: 20400

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/02/2021, 11/03/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Human Services Licensing Supervisor

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: *MAPLE SHADE MEADOWS SENIOR LIVING* **License #**: *20400* **License Expiration**: *11/20/2022*

Address: *50 EAST LOCUST STREET, NESQUEHONING, PA 18240*

County: *CARBON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/14/2017* **Issued By**: *Borough of Nesquehoning*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *65* **Waking Staff**: *49*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/03/2021*

Inspection Dates and Department Representative

11/02/2021 - On-Site:
11/03/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served**: *52*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *0* **Capacity**: *38* **Residents Served**: *13*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *52*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *13* **Have Physical Disability**: *0*

Inspections / Reviews

11/02/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/09/2022*

01/24/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/28/2022*

02/28/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/08/2022*

04/12/2022 - Document Submission

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Resident #2 had documentation in his/her file that an active protective services investigation began on 12/22/20. However, the Home did not complete an Act 13 and submit to the Area Agency on Aging.

Plan of Correction ***Accept***

All medication and management staff have been reminded that all potential abuse cases must be reported to DHS and The Office of Aging within 24 hours. Administrator will be responsible for following through on all abuse reports.

Completion Date: *11/20/2021*

Update: *01/24/2022*

Please send/Attach proof of staff training. 1-24-2022 MM

Document Submission ***Implemented***

See attached proof

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

Resident #2 had documentation in his/her file that an active protective services investigation began on 12/22/20. The home failed to notify the Department of the alleged abuse.

Plan of Correction ***Accept***

All medication and management staff have been reminded that all potential abuse cases must be reported to DHS and The Office of Aging within 24 hours. Administrator will be responsible for following through on all abuse reports.

Completion Date: *11/20/2021*

Update: *01/24/2022*

Please send/Attach proof of staff training. 1-24-2022 MM

Document Submission ***Implemented***

See attached proof of attached training

17 - Record Confidentiality

1. Requirements

2600.

17 - Record Confidentiality *(continued)*

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

Description of Violation

At 5:10pm on 11/3/21, the Medication Administration records book was located on top of the Med Cart in memory care. Additionally, the Narcotic count book was in an unlocked bin on the side of the cart, giving access to resident's personal information. Both books with confidential information were accessible while no staff members were present.

Plan of Correction ***Accept***

Staff were giving 5 o'clock meds and had walked away from the cart. Medical staff have been reminded about locking MARS and narcotic count book in the med-cart at all times. They must do this even when passing medications, if they walk away from the med-cart. Administrator and DON will be responsible for sporadically checking all med carts for locked books.

Completion Date: *11/22/2021*

Update: *01/24/2022*

Please send/Attach proof of staff training. 1-24-2022 MM

Document Submission ***Implemented***

See attached documentations/proof of staff training

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home did not change and date the batteries in the homes CO2 monitor on an annual basis. Co2 detectors are in all rooms that have gas fired heating systems. Rooms A5, A11, A15, A12, A119, and A18's co2 monitor batteries were dated 12/12/18.

The home had no documentation that the gas boiler was inspected as required. The boiler was install during 2020 but did not have an inspection by Labor and Industry.

Plan of Correction ***Accept***

All batteries in the building were changed (if necessary) and dated on the day of inspection while inspector was in the building. Management, maintenance, and housekeeping were taught on the day of inspection that they would be responsible for dating al batteries being used for CO2 monitors. Maintenance supervisor is responsible for checking everything is dated and within regulation.

Gas boiler has been inspection. Please see attached documentation. Maintenance supervisor will be responsible for ensuring all equipment is properly inspected and within regulation.

Completion Date: *11/20/2021*

Update: *01/24/2022*

Immediately and ongoing - The administrator shall ensure and be responsible for ongoing compliance.

18 - Compliance With Laws (continued)

1-24-2022. MM

Document Submission ***Implemented***

Administrator will be responsible for ensuring compliance.

26a - Quality Management Plan

1. Requirements

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

Description of Violation

The quality management plan review did not include the names of the staff involved in the review.

Plan of Correction ***Accept***

Staff names were added to the quality management plan. Administrator will be responsible for quality management plan and all staff who participate will sign it.

Completion Date: *11/20/2021*

Document Submission ***Implemented***

Staff names were added to the quality management plan. Administrator will be responsible for quality management plan and all staff who participate will sign it.

52 - Hiring Staff

1. Requirements

2600.
52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons 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) and other applicable regulations.

Description of Violation

Staff A was hired on ███ and resigned on ███. Staff A was re-hired on ███. Staff A background check was dated ███. The background check was more than 12 months old.

Plan of Correction ***Accept***

All supervisors were trained on background checks and the requirements as stated in 2600.52. All background checks must be done within 12 months of hire date. Administrator will check all new hire paperwork to ensure all background checks are done within 12 months and that all new hires will have a background check done by Maple Shade Meadows.

Completion Date: *11/20/2021*

Update: *01/24/2022*

Immediately and ongoing:
The administrator will develop and implement a system to ensure that hiring and retention of staff is done in accordance with the Older Adults Protective Services Act. 1-24-2022 MM

Document Submission ***Implemented***

All background checks completed in accordance with Older Adults Protective Services Act.

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

The home did not have a High School Diploma, GED, or active Nursing Aide Assistant registry for Staff B, hired [redacted] and staff C, [redacted]

Plan of Correction ***Accept***

Supervisors were reminded to obtain all required documents during the hiring process. Administrator will be responsible for all staff files to be completed with all required forms.

Completion Date: *11/20/2021*

Update: *01/24/2022*

Please send/Attach proof of compliance for both staff person B and C. 1-24-2022 MM

Document Submission ***Implemented***

Proof of compliance attached

141a - Medical Evaluation

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.

Description of Violation

Resident #1's most recent medical evaluation was completed on [redacted]. However, the medical evaluation was not signed by a physician.
Resident #2's medical evaluation was completed on [redacted]. No information was listed for the resident's weight, height, and temperature.
Resident #3's most recent medical evaluation was completed on [redacted]. The medical evaluation did not contain resident's height and it was not missing the medical professionals name and license number.
Resident #4's height is not indicated on the residents most recent medical evaluation on [redacted]. Resident #5 medical assessment completed on [redacted] does not contain the medical professionals name or license number.

Plan of Correction ***Accept***

A training was held with all med-techs concerning how to fill out medical evaluations and information that is required to be filled out by physician, physician assistant, or nurse practitioner. They were taught to never leave any empty blanks on state required paperwork. Administrator will be responsible for checking Med-Evals sporadically.

Completion Date: *11/22/2021*

Update: *01/24/2022*

Please send/Attach proof of staff training. 1-24-20222 MM

Document Submission ***Implemented***

A training was held with all med-techs concerning how to fill out medical evaluations and information that is required to be filled out by physician, physician assistant, or nurse practitioner. They were taught to never leave any empty blanks on state required paperwork. Director of nursing will be responsible for ensuring Med-Evals are completed. Administrator to check sporadically.

184b - Resident's Meds Labeled

1. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Located in memory care cart were the following medications -- melatonin, D3, Ocusoft lid scrub, Preservision, Zyrtec, align antibiotic ointment, calcium 600mg, fish oil 1200 mg, vitamin C 500mg, calcium 1200mg, D3 50mg, Multivitamin for her, B6 100mg, equate pain reliever 500mg, curad oil emulsion dressing. None of these medications had resident's name on them.

Plan of Correction ***Accept***

All medical personnel were retrained to label residents name and date all OTC and CAM medications. Administrator and DON will be responsible for monitoring med-carts and OTC and CAM meds.

Completion Date: *11/22/2021*

Update: *01/24/2022*

Please send/Attach proof of staff training. 1-24-2022 MM

Document Submission ***Implemented***

All medical personnel were retrained to label residents name and date all OTC and CAM medications. Administrator and DON will be responsible for monitoring med-carts and OTC and CAM meds.

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:
14. Name and initials of the staff person administering the medication.

Description of Violation

Staff did not sign or initial the Medication Administration Record of resident #2 on [redacted] to indicate that [redacted] had been administered at 8am.

Plan of Correction ***Accept***

Med-techs were retrained on medication procedures including signatures on MARS and following prescriber orders. The training also included the issue of never leaving blank forms. Administrator and DON are responsible for monitoring signatures of medical staff on all medical forms. Facility has switched to LTC pharmacy and will be switching to electronic MAR in the near future to ensure accuracy of med-pass.

Completion Date: *11/22/2021*

Update: *01/24/2022*

Please include in plan of correction, who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen. 01-24-2022 MM

Document Submission ***Implemented***

Director of Nursing and Administrator will be responsible for ensuring all MARS are signed appropriately. Facility recently switched to electronic MAR system, Quick Mar, to ensure accuracy of documentation.

187d - Follow Prescriber's Orders

1. Requirements

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

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

Description of Violation

On 10/18/21 and 10/19/21 resident #2 did not get [redacted] at 8am due to medication not available in the home. Additionally, on 10/29/21, [redacted] were not administered at 8am.

Plan of Correction ***Accept***

Med-techs were retrained on the medication procedures and to alert DON and administrator of any medications that are not available. DON will be responsible for sporadically checking MAR and med-carts.

Completion Date: *11/22/2021*

Update: *01/24/2022*

Please include in plan of correction, who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen. 01-24-2022 MM

Document Submission ***Implemented***

Director of Nursing will be responsible for ensuring all MARS are signed appropriately. Facility recently switched to electronic MAR system, Quick Mar, to ensure accuracy of documentation. Quick Mar is directly connected to pharmacy to allow easier communication, and to ensure all medications are available at all times.

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 #2 was admitted to the home on [redacted]. However, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept***

Staff member who was responsible for assessment at time of Resident #2's admission is no longer employed with Maple Shade Meadows. Additionally, administrator and DON were reminded of the preadmission screening form and its requirement of being done at the time of the assessment and within 30 days prior to admission. Administrator will be responsible for the completion of this form.

Completion Date: *11/22/2021*

Update: *01/24/2022*

Please include in plan of correction, who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen. 01-21-2022 MM

Document Submission ***Implemented***

Staff member who was responsible for assessment at time of Resident #2's admission is no longer employed with Maple Shade Meadows.
The administrator and DON were reminded of the preadmission screening form and its requirement of being done at the time of the assessment and within 30 days prior to admission.
Director of nursing will be responsible for ensuring completion of required documentation.
Administrator to check sporadically that required documentation is appropriately filled out.

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 #2 was admitted on 11/7/20. The resident's initial assessment was completed on 12/23/20, more than 15 days after their date of admission.

Plan of Correction ***Accept***

Administrator and DON were reminded that initial assessments need to be completed within 15 days of admission. Administrator will be responsible for ensuring all assessments and required forms are completed on time.

Completion Date: *11/22/2021*

Document Submission ***Implemented***

Administrator and DON were reminded that initial assessments need to be completed within 15 days of admission. Administrator will be responsible for ensuring all assessments and required forms are completed on time.

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's Medical Assessment, [redacted], states Resident is on a regular diet with thinned liquids. Residents diet is not stated in her Assessment or Support plan.
Resident #3's medical evaluation was completed on [redacted]. The medical assessment stated Resident #3 was on a nectar thick mechanical soft, this information was not included on his/her Assessment and Support plan.
Resident #4's Medical Assessment completed on [redacted] indicated resident is on a regular diet with thinned liquids. Resident #4's diet is not stated in his/her assessment and support plan.

Plan of Correction ***Accept***

All employees who write or add to RASP will be trained on filling out the RASP and all areas. New employees have been hired and are slowly being trained in all of the state required resident forms for their records. Administrator and DON will monitor all resident records.

Please be advised: A regular diet with thin liquids in medical terms indicates that there are no restrictions. At the time of inspection, inspector indicated thin liquids means the resident is unable to have thick liquids such as milkshakes and smoothies, but that is not what thin liquids indicates.

Completion Date: *11/22/2021*

Document Submission ***Implemented***

All employees who write or add to RASP will be trained on filling out the RASP and all areas. New employees have been hired and are slowly being trained in all of the state required resident forms for their records. Administrator and DON will monitor all resident records.

227d - Support Plan Medical/Dental (continued)

Please be advised: A regular diet with thin liquids in medical terms indicates that there are no restrictions.
***At the time of inspection, inspector indicated thin liquids means the resident is unable to have thick liquids such as milkshakes and smoothies, but that is not what thin liquids indicates. ***

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 #1 participated in the development of her/his support plan on [redacted]. Resident #4 participated in the development of her/his support plan on [redacted]. Resident #5 participated in the development of her/his support plan on 10/11/21. However, the residents did not sign the support plan. No indication the residents was unable/refused to sign.

Plan of Correction ***Accept***

Administrator and DON are responsible for RASPS. They are aware of the resident signatures on the RASPS and will make sure residents sign their RASPS or indicate a refusal/unable to sign.
Completion Date: *11/22/2021*

Document Submission ***Implemented***

Administrator and DON are responsible for RASPS. They are aware of the resident signatures on the RASPS and will make sure residents sign their RASPS or indicate a refusal/unable to sign.

252 - Record Content

1. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

The record of resident #2 did not include the resident's race, hair color, eye color, and a dated picture. The record of resident #4 and resident #5 does not include the residents eye color.

Plan of Correction ***Accept***

Administrator and DON have been reminded about never leaving any blanks open on any forms required for resident records. They were trained on the importance of the descriptions for each resident. Facility has hired an administrative assistant to assist with and monitor resident charts for completion and accuracy.
Completion Date: *12/01/2021*

Document Submission ***Implemented***

Administrator and DON have been reminded about never leaving any blanks open on any forms required for resident records. They were trained on the importance of the descriptions for each resident. Facility has hired an administrative assistant to assist with and monitor resident charts for completion and accuracy.

65a - FS Orientation 1st Day

1. Requirements

2600.

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

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:

Description of Violation

Staff person A , whose first day of work was [redacted], and staff person B, whose first day of work was [redacted] did not receive orientation on training topics #1 through 7.
repeat violation 10/10/19

Plan of Correction ***Accept***

All supervisors have been retrained on the orientation and new employee training. They will be held responsible for their own staff training. There has been a basic orientation program created which includes fire safety and emergency preparedness. All staff is being trained on the orientation topics plus the topics in the first 40 hours. The administrator will be responsible ensuring supervisors are adequately training new employees.

Completion Date: *11/20/2021*

Update: *01/24/2022*

Please send/Attach proof of staff training. 1-24-2022 MM

Document Submission ***Implemented***

Supervisors to ensure all staff are trained appropriately

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:

Description of Violation

Staff person A, who completed their first 40 hours of work on [redacted], and staff person B, whose completed their first 40 hours of work on [redacted] did not complete training topics #1 through #4.
repeat violation 10/10/19

Plan of Correction ***Accept***

All supervisors have been retrained on the orientation and new employee training that has to be completed in the first 40 hours. They will be held responsible for their own staff training. There has been a basic orientation program created which includes fire safety and emergency preparedness. All staff is being trained on the orientation topics plus the topics in the first 40 hours. The administrator will be responsible ensuring supervisors are adequately training new employees.

Completion Date: *11/22/2021*

Update: *01/24/2022*

Please send/Attach proof of staff training. 1-24-2022 MM

Document Submission ***Implemented***

All supervisors have been retrained on the orientation and new employee training that has to be completed in the first 40 hours. They will be held responsible for their own staff training. There has been a basic orientation program created which includes fire safety and emergency preparedness. All staff is being trained on the orientation topics plus the topics in the first 40 hours. The administrator will be responsible ensuring supervisors are adequately training new employees.

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:

Description of Violation

Direct care staff person B, hired on [redacted] was proving direct care to resident but did not complete and pass the Department-approved direct care training course and pass the competency test until [redacted] and staff person D, was hired on [redacted], did not complete and pass the Department approved direct care training course and pass the competency test.
repeat violation 10/10/19

Plan of Correction ***Accept***

All new caregivers will be required to take the direct care training and take the competence test before doing resident care. The DON and administrator will be responsible for monitoring this training.

Completion Date: *11/22/2021*

Update: *01/24/2022*

Please send/Attach proof of staff training for staff person D. 1-24-2022 MM

Document Submission ***Implemented***

Please see attached staff training

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

The telephone numbers required by this regulation were not posted by the phones located in room # NW12.

Plan of Correction ***Accept***

Phone numbers were posted in room NW 12, but resident removed phone numbers, she stated she did not want them posted in her room. She stated this while inspector was present. Every time a number list is placed, she throws it away. Administrator will continue to work with her to choose a place where she is willing to post the required telephone numbers.

Completion Date: *11/22/2021*

Update: *01/24/2022*

Please send proof of compliance (picture). 1-24-2022 MM

Document Submission ***Implemented***

Phone numbers were posted in room NW 12, but resident removed phone numbers, [redacted] stated [redacted] did not want them posted in [redacted] room. [redacted] stated this while inspector was present. Every time a number list is placed, [redacted] throws it away. Administrator will continue to work with [redacted] to choose a place where [redacted] is willing to post the required telephone numbers. Phone number has been reposted

185a - Implement Storage Procedures

1. Requirements

185a - Implement Storage Procedures *(continued)*

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #2 is prescribed [redacted]. The resident did not receive this [redacted] on 10/11/21 and [redacted] on 10/18/21 and 10/19/21 due to the medication not available in the home.

The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident #7 – At 9:23pm on 10/28/21 the reading on the glucometer was 220 but was incorrectly transcribed as 227. Resident #8 – At 11am on 10/3/21 the reading on the glucometer was 405 but was incorrectly transcribed as 400.

repeat violation 10/10/19

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

Violation does not match regulation 2600.185a

Completion Date: *11/20/2021*

Update: *01/24/2022*

Please include in plan of correction, who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen. 01-24-2022 MM

Please refer to the Departments wed-site for the latest policy and regulation updates.

Plan of Correction ***Accept***

Staff were re-educated on 2600.185 (a). Facility is transitioning to electronic medication administration in order to ensure the accuracy of records.

Attached is proof of staff training on all topics listed above: 15a, 16c, 17, 54a, 141a, 184a, 65a, 65b, 65d, 91

Proof of Posted Telephone Numbers

Compliance of Staff Person B &C

Completion Date: *12/14/2021*

Update: *02/28/2022*

Document Submission ***Implemented***

Administrator and Director of Nursing to ensure compliance with 2600.
185.a.
Staff were retrained on ensuring all medications are appropriately stored, labeling and distributed.