Department of Human Services
Bureau of Human Service Licensing

July 13, 2022

[redacted], OWNER
[redacted]

RE: GRAND AT FAYETTE D/B/A
COUNTRY CARE MANOR
205 COLDREN ROAD
FAYETTE CITY, PA, 15438
LICENSE/COC#: 44959

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/14/2022, 02/15/2022, 02/16/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *GRAND AT FAYETTE D/B/A COUNTRY CARE MANOR* **License #:** *44959* **License Expiration:** *05/15/2022*

Address: *205 COLDREN ROAD, FAYETTE CITY, PA 15438*

County: *FAYETTE* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *GRAND AT FAYETTE LLC*

Address: *820 CORAL AVENUE, LAKEWOOD, NJ, 8701*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *03/12/1993* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *39* **Waking Staff:** *29*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *02/16/2022*

Inspection Dates and Department Representative

02/14/2022 - On-Site: [redacted]
02/15/2022 - On-Site: [redacted]
02/16/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served:** *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *4* **Are 60 Years of Age or Older:** *33*

Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *6* **Have Physical Disability:** *0*

Inspections / Reviews

02/14/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/25/2022*

Inspections / Reviews *(continued)*

03/25/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/31/2022*

04/04/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/15/2022*

07/13/2022 - Document Submission

Reviewer: [redacted] **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 2/14/22, the home's most recent license inspection summaries, dated [redacted] and [redacted], were not posted in a public and conspicuous place in the home.

Plan of Correction ***Accept***

3.c
What: Previous licensing inspection summaries were not available during the inspection. The September 20, 2021 and November 10, 2021 were placed in the main community lobby.
Who: The administrator
When: 2/14/2022
How: The administrator immediately located the licensing summary and added them as noted.
Ongoing: Monthly or more frequent, as needed, checks of the needed items related to 2600.3(c) will be completed by the administrator or designee.

Completion Date: *02/14/2022*

Document Submission ***Implemented***

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

On 2/14/22, there was no influenza poster posted in a public and conspicuous place in the home in accordance with the Influenza Awareness Act, enacted in July, 2016.

Plan of Correction ***Accept***

18
What: Influenza poster was not posted as required. The correct poster was located and posted.
Who: The administrator.
When: 2/14/2022
How: The administrator immediately located the poster and placed it as required within the community.
Ongoing: Monthly or more frequent, as needed, checks of the needed items related to 2600.18 will be completed by the administrator or designee.

Completion Date: *02/14/2022*

Document Submission ***Implemented***

25a - Written Contract and Review

1. Requirements

2600.

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

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

No resident-home contract was completed for resident #3, who was admitted to the home on 1/29/19.

Plan of Correction ***Directed***

25(a)

What: Resident contract was not available during the February 14-16, 2022 inspection. It is unclear at this time why the contract was missing, but in speaking with the resident and responsible party, it was completed on the date of admission. A replacement contract was provided as outlined in the when section below. An audit of all resident contracts were completed and all other contracts were available.
Who: Designee
When: February 24, 2022, the resident #3 and her responsible party met with the community designee who presented the replacement resident contract. (DIRECTED: A copy of the completed resident-home contract shall be kept in resident #3's record. LM 4/4/22
How: In person meeting with the resident and responsible party.
The resident record audit was a resident-by-resident review.
Ongoing: The community will be working with their electronic records provider to upload such resident records so that such occurrences as missing resident contracts will not occur. The administrator/designee will add a reminder to the Tabula Pro calendar via the dashboard by 4/30/22. This will serve as a visual cue that the task, in this case uploading the executed resident contract for new residents. This calendar will be reviewed daily to ensure all tasks are completed in a timely manner

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attached

26b - Quality Management Plan Content

1. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

Description of Violation

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

Plan of Correction ***Directed***

26(b)

26b - Quality Management Plan Content (continued)

What: Quality management plan records were not available during the 2/14-16/2022 inspection. It is unclear currently why the records were not available. A quality management policy was adopted with new a new quality management meeting reviewing Q1 2022 to take place by 4/30/2022. (DIRECTED: Documentation of all completed quality management meetings shall be kept. LM 4/4/22)
Who: The administrator or designee along with key community staff.
When: Immediately with the initial meeting according to the policy to be held by 4/30/2022.
How: Using the Tabula Pro electronic residents records, quality management template.
Ongoing: The community will conduct appropriate quality management systems as outlined in the community quality management policy. The administrator/designee will add to the Tabula Pro calendar via the dashboard. This will serve as a visual cue that the task, in this case completing the scheduled quality management meeting including documentation. The calendar will be monitored daily to ensure all tasks are completed in a timely manner.

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attached

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

Direct care staff person A was hired on [redacted]; however, the staff person's Pennsylvania criminal background check was not completed until [redacted]

Staff person C, the home's administrator, was hired on [redacted] however, the staff person's Pennsylvania criminal background check was not completed until [redacted].

Plan of Correction ***Directed***

51

What: Criminal background checks for staff person A and C were not available on [redacted]. While it is unclear as to why the checks were not available, the missing background check on staff member C was previously self-identified by the community and completed prior to the inspection. Staff person C was hired on [redacted] but was hired for a different role, staff person C became administrator on [redacted] Staff person A's background check was immediately run through the PA State Police PATCH system after being identified.
Who: The administrator.
When: 2/14/2022, with employee records audited and found to be in compliance on 2/21/2022, training checklist training on or before 4/15/2022 (DIRECTED: Documentation of the training related to the checklist shall be kept. LM 4/4/22).

51 - Criminal Background Check (continued)

How: The community used the PA State Police PATCH system.
Ongoing: The community will begin using the Tabula Pro electronic records system so that all such records will be available digitally to ensure that they are consistently available as needed or requested. Using an updated "new hire" training and checklist form the completed background checks will be included. The administrator/designee will add a reminder to Tabula Pro calendar via the dashboard. This will serve as a visual cue that the task, in this case ensuring that the appropriate background check has been received prior to the new employee start date. The calendar will be monitored daily to ensure all tasks are completed in a timely manner. As outlined in 65(a), all hiring supervisors will be trained on the use of this new checklist. (DIRECTED: Documentation of the education shall be kept. [redacted] /4/22).

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attached

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:

Description of Violation

Direct care staff person B, hired on [redacted], did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction ***Directed***

65 (a)

What: Staff person B's initial orientation was not available during the 2/14-16/2022 inspection. While it is unclear why the initial orientation materials were not available, the orientation was completed a required. An audit of all staff records did not identify any other such gap in records. (DIRECTED: Documentation of the completed 2600.65a trainings shall be kept in staff person B's record. [redacted] 4/4/22).
Who: administrator/designee.
When: 2/14/2022, with the audit completed on 2/21/2022. Training on the use of the new checklist will be completed on or before 4/15/2022 (DIRECTED: Documentation of the training related to the checklist shall be kept. LM 4/4/22).
How: Using a community checklist, the trainer and staff person B completed the required training using verbal review of the required topics.
Ongoing: The checklist will be used with each new hire and the community will begin working with its electronic records vendor to upload all such documents to avoid such gaps in the future. Using the updated "new hire" training checklist form, all required new hire training will be identified. The administrator/designee will add a reminder to the Tabula Pro calendar via the dashboard, this will serve as a visual cue that the task, in this case ensuring that the appropriate training for newly hired staff is completed as required. The calendar will be monitored daily to ensure

65a - FS Orientation 1st Day (continued)

all tasks are completed in a timely manner.

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attached

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

Direct care staff person B, hired on [redacted], did not receive orientation on any of the topics specified in 2600.65b.

Plan of Correction ***Directed***

65 (b)

What: Staff person B's initial orientation was not available during the 2/14-16/2022 inspection. While it is unclear why the initial orientation materials were not available, the orientation was completed a required. An audit of all staff records did not identify any other such gap in records. (DIRECTED: Documentation of the completed 2600.65b trainings shall be kept in staff person B's record. [redacted] 4/4/22).
Who: administrator/designee.
When: 2/14/2022, with the audit completed on 2/21/2022. Training on the use of the new checklist will be completed on or before 4/15/2022. (DIRECTED: Documentation of the training related to the checklist shall be kept. [redacted] 4/4/22).
How: Using a community checklist, the trainer and staff person B completed the required training using verbal review of the required topics.
Ongoing: The checklist will be used with each new hire and the community will begin working with its electronic records vendor to upload all such documents to avoid such gaps in the future. Using the updated "new hire" training checklist form, all required new hire training will be identified. The administrator/designee will add a reminder to the Tabula Pro calendar via the dashboard, this will serve as a visual cue that the task, in this case ensuring that the appropriate training for newly hired staff is completed as required. The calendar will be monitored daily to ensure all tasks are completed in a timely manner.

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attached

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

On 2/15/22, there were numerous dried blood stains on resident #4's [redacted] 2 glucometer.

Plan of Correction ***Directed***

85.a.

What: Blood stains were found on resident #4's glucometer. The stains were immediately cleaned and disinfected. Staff will be retrained on the proper procedures to use and ensure sanitary conditions on residents glucometers. All other glucometers were checked and no other problems were found
Who: The administrator and designee will retrain all Med Tech's. They also completed the cleaning and disinfection as noted above.
When: Immediately on 2/14/2022, with retraining completed on 2/21/2022. (DIRECTED: Documentation of the training shall be kept. [redacted] 4/4/22). Audit of other community glucometers was completed on 2/14/2022
Ongoing: All glucometers will be checked at shift change with at least monthly checks by the administrator or designee. (DIRECTED: Documentation of the monthly checks shall be kept. [redacted] 4/4/22).

Completion Date: *04/01/2022*

Document Submission ***Implemented***

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 2/14/22, the door leading to the basement level of the home was unlocked and unattended. The basement level is currently under construction and numerous construction materials and tools, including a table saw, were located throughout the basement level.

On 2/14/22, the exit door next to bedroom #28 required significant force by an agent of the Department to open the door.

Plan of Correction ***Directed***

88(a)

What: The door leading to the lower level of the home was unlocked and unattended. A lock was placed on the evening of 2/14/2022, an alarm was placed on the inside of the door to alert staff that is on the lower level that someone is entering and to look for that person prior to going back up to the main floor and locking the door.
Who: Administrator
When: 2/14/2022

88a - Surfaces (continued)

Ongoing: This system will remain in place until construction on the lower level is complete.
Completion Date: ongoing
(DIRECTED: Within 48 hours of receipt of the plan of correction: Until all repairs are made to the basement level, a designated staff person shall inspect the basement door daily to ensure the door is locked. [redacted] 4/4/22).
88(a)
What: The home respectfully disagrees with this violation. The door by room #28 was not blocked or required significant force to be opened, but was "sticking" The fire chief was at the home on 2/17/2022 and determined ALL egress' were in proper working order. The letter was submitted to Human Services Licensing Representative and her supervisor via email. To further ensure the door's functionality, Todd Reppert, a fireman from Wash Twp VFD lightly sanded the door to allow door to open more freely on 3/11/2022. All community staff will be trained on the procedure to identify and report such potential concerns during the next, all community staff meeting on or before 4/30/2022 (DIRECTED: Documentation of the education shall be kept. [redacted] 4/4/22).
Who: Fire Chief [redacted], Fireman [redacted]
When: 2/14/2022 and 3/11/2022
Ongoing: The home will continue to check all of the egress' with every monthly fire drill and or all fire safety inspections conducted. The Director of Environmental Services/maintenance will conduct a monthly audit on all floors, walls, ceilings, windows, doors and other surfaces to ensure they are in good repair and free from hazards starting 4/30/2022. (DIRECTED: Documentation of the monthly audits shall be kept. [redacted] 4/4/22).
Completion Date: 02/10/2022

DIRECTED: Within 48 hours of receipt of the plan of correction: A designated staff person shall inspect all floors, walls, ceilings, windows, doors and other surfaces to ensure they are clean, in good repair and free of hazards. [redacted] 4/4/22

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attached

92 - Windows

1. Requirements

2600.

92 - Windows *(continued)*

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 2/15/22, there were no screens in the 2 operable windows of the shared bedroom of residents #4, #6, and #7.

On 2/15/22, there were no screens in the 3 operable windows located in the left side of the dining room, and no screen in 1 of the operable windows located in the right side of the dining room.

Plan of Correction ***Directed***

92.

What: The home respectfully disagrees with this violation. 2600.92 (in which is described in the requirements of 92-Windows) in above mentioned text... Windows, including windows in doors, must be in good repair and securely screened when doors or windows are "open"... no windows were open during the inspection.
Who: The administrator or designee
When: The home will have maintenance department put screens in, fix any damaged screens and will be completed by 4/15/2022. (DIRECTED: By 4/15/22, then monthly thereafter: A designated staff person shall check all operable windows in the home, including the operable windows in the shared bedroom of residents #4, #6 and #7 and the left and right sides of the dining room, to ensure a well-secured screen is present. [redacted] 4/4/22.

Completion Date: *04/01/2022*

Document Submission ***Implemented***

please see attachment

96a - First Aid Kit

1. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The home's first aid kit does not contain adhesive bandages, scissors or tweezers.

Plan of Correction ***Directed***

96(a)

What: The community first aid kit did not include all of the items in required in 96(a) The items were replaced. A new system was put into place as follows:
1) A breakable tab will be used to show that the kit has not been used
2) The tab will be dated to identify when the kit was last checked

96a - First Aid Kit (continued)

3) Anytime the kit is used, it will be checked, restocked as needed, and a new tab with date will be added by the administrator or designee.
4) The staff will be educated on this new system by 4/15/2022 (DIRECTED: Documentation of the education shall be kept. LM 4/4/22).
This tab will allow for easy visual confirmation that the first aid kit and its required contents are intact. Staff will be trained on new system prior to its implementation
Who: Administrator/designee
When: Items restocked on 2/17/2022, the new visual identification system will be completed by 4/15/2022
Ongoing: The administrator/designee will check the first aid kit at least monthly to ensure that the system is in place and that it is stocked per regulation.

Completion Date: *04/01/2022*

Document Submission ***Implemented***

please see attached

101j7 - Lighting/Operable Lamp

1. Requirements

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

Description of Violation

Resident #3's bedside lamp is approximately 2.5' from the resident's bed and cannot be turned on/off from bedside.

Plan of Correction ***Directed***

101(j)

The bedside lamp was found to be out of resident #3's reach. A touch light was immediately installed allowing resident #3 easy access to this light source. The housekeeping staff will complete a check of all needed lamps weekly or more often to ensure they are working and in proper locations.
Who: Administrator
When: 2/14/2022, staff to be trained on or before 4/30/2022 (DIRECTED: Documentation of the education shall be kept. [redacted] 4/4/22).
How: Outside purchase of new lamp, training will be one on one or in a group.
When: Weekly checks to begin after all staff are trained as above in "when". (DIRECTED: By 4/11/22: A designated staff person shall conduct an initial inspection all resident bedrooms to ensure each resident has an operable lamp or other source of lighting present that can be turned on/off at bedside. [redacted] 4/4/22).
Ongoing: The administrator/designee will audit at least 10% of all apartments, at least monthly to ensure that all required items are in place.

101j7 - Lighting/Operable Lamp (continued)

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attachment

132a - Monthly Fire Drill

1. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not conducted in December, 2021 and January, 2022.

Plan of Correction ***Directed***

132(a)

What: Fire drills were not restarted following the Departments post COVID directions. In addition, the required fire safety inspection was also not completed. The home self-identified these conditions and had already contacted Wash Twp VFD and Reliant Systems LLC on 2/10/2022. This inspection and fire drill planning was scheduled and conducted on 2/17/2022. Reliant Systems in to inspect fire equipment on 2/16/2022 and was found to be in proper working order. The paper work was submitted to Human Services Licensing Representative and her Supervisor via email. A fire safety training for all staff was completed on 3/10/2022 An unannounced fire drill was conducted on 3/22/2022. (DIRECTED: Documentation of the fire safety training shall be kept. [redacted] 4/4/22).
Who: The administrator/designee with [redacted] of Fire Solutions
When: 2/10/2022, 2/17/2022 and 3/22/2022
Ongoing: Following the training above, the community will complete fire drills and other requirements of 132 on a regular basis. Such records will be stored electronically in Tabula Pro on or before 6/30/2022. The administrator/designee will add a recurring reminder on Tabula Pro calendar via the dashboard. This will serve as a visual cue that the task, in this case ensuring that fire drills are scheduled and completed. The calendar will be monitored daily to ensure all tasks are completed in a timely manner.

DIRECTED: Within 72 hours of receipt of the plan of correction: A designated staff person shall review the fire drill records monthly to ensure an unannounced fire drill is conducted at least monthly. [redacted] 4/4/22).

Completion Date: *04/01/2022*

Document Submission ***Implemented***

please see attached

132b - Safety Inspection/Fire Drill

1. Requirements

2600.

132b - Safety Inspection/Fire Drill *(continued)*

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The most recent fire safety inspection and fire drill conducted by a fire safety expert was completed on 8/20/19.

Plan of Correction ***Directed***

132(b)

What: Fire drills were not restarted following the Departments post COVID directions. In addition, the required fire safety inspection was also not completed. The home self-identified these conditions and had already contacted Wash Twp VFD and Reliant Systems LLC on 2/10/2022. This inspection and fire drill planning was scheduled and conducted on 2/17/2022. Reliant Systems in to inspect fire equipment on 2/16/2022 and was found to be in proper working order. The paper work was submitted to Human Services Licensing Representative and [redacted] Supervisor via email. An observed fire drill and fire safety training for all staff was completed on 3/10/2022 An unannounced fire drill was conducted on 3/22/2022 .
Who: The administrator/designee with [redacted] of Fire Solutions
When: 2/10/2022, 2/17/2022 and 3/22/2022
Ongoing: Following the training above, the community will complete fire drills and other requirements of 132 on a regular basis. Such records will be stored electronically in Tabula Pro on or before 6/30/2022. The administrator/designee will add a recurring reminder on Tabula Pro calendar via the dashboard. This will serve as a visual cue that the task, in this case ensuring that fire drills are scheduled and completed. The calendar will be monitored daily to ensure all tasks are completed in a timely manner.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure a fire safety inspection and fire drill conducted by a fire safety expert is completed at least annually. Documentation of the system shall be kept. Documentation of the fire safety inspection and fire drill conducted by a fire safety expert shall be kept. [redacted] 4/4/22

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see 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 #2 was admitted to the home on [redacted] however, the resident's medical evaluation was completed on

141a - Medical Evaluation (continued)

7/12/21, which exceeds 60 days prior to admission.

Plan of Correction ***Directed***

141(a)

What: Resident #2 was admitted to the home on [redacted] with the residents medical evaluation completed on [redacted], which exceeds 60 days prior to admission. Residents MD was immediately notified, per MD, resident was seen in his office on 1/17/2022. A DME was completed from that appointment date and signed on 2/16/2022. (DIRECTED: A copy of resident #2's most recent medical evaluation shall be kept in the resident's record. LM 4/4/22).
Who: Administrator/designee
When: immediately on 2/14/2022 when identified
How: All residents' charts was audited on 2/21/2022 and did not identify any other gap in records.
Ongoing: Administrator and designee will audit new admission paperwork to ensure proper documentation/dating and will add a recurring reminder to Tabula Pro calendar via the dashboard. This will serve as a visual "tickle" cue that the task, in this case ensuring that all new resident records such as medical evaluations are completed per regulation. This calendar will be monitored daily to ensure all noted tasks are completed in a timely manner.

Completion Date: *04/01/2022*

Document Submission ***Implemented***

please see attached

141b1 - Annual Medical Evaluation

1. Requirements

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

Description of Violation

Resident #4's most recent medical evaluation, dated [redacted], is not signed by a medical professional and does not indicate a medical professional's license number. These sections of the form are blank.

Plan of Correction ***Directed***

141(b).1
What: Resident #4 most recent medical evaluation dated [redacted] was not signed by a medical professional and does not indicate a medical professional's license number. Immediately upon finding CRNP was notified of above.

Who: Administrator/designee/CRNP

When: 2/14/2022 , medical evaluation was signed 2/23/2022
(DIRECTED: Within 14 calendar days of receipt of the plan of correction: A new medical evaluation shall be completed in its entirety for resident #4. A copy of the new medical evaluation shall be kept in resident #4's record. [redacted] 4/4/22).

141b1 - Annual Medical Evaluation (continued)

How: All residents' charts was audited on 2/21/2022 and did not identify any other gap in records.

Ongoing: The administrator and designee will audit all DME's after completion for medical professionals signature and license number

Ongoing: Administrator and designee will audit new admission/resident paperwork to ensure proper documentation/dating and will add a recurring reminder to Tabula Pro calendar via the dashboard. This will serve as a visual "tickle" cue that the task, in this case ensuring that all new resident/resident records such as medical evaluations are completed per regulation. This calendar will be monitored daily to ensure all noted tasks are completed in a timely manner.

Completion Date: *04/01/2022*

Document Submission ***Implemented***

please see attached

183f - Discontinued Medications

1. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

The home's first aid kit contains 6 packets of Aspirin, each packet containing 2 tablets each; however, the Aspirin packets expired in June, 2018.

Plan of Correction ***Directed***

183(f)

What: The home's first aid kit contained 6 packets of aspirin, each packet containing 2 tablets each. The first aid kit will not have aspirin in the kit and the following shall happen.
1) A breakable tab will be used to show that the kit has not been used
2) A tab will be dated to identify when the kit was last checked
3) Anytime the kit is used, it will be checked, restocked as needed, and a new tab with date will be added by the administrator or designee.
4) The licensing representative discarded the expired aspirin tablets
This tab will allow for easy visual confirmation that the first aid kit and its required contents are intact. Staff will be trained on new system prior to its implementation
Who: Administrator/designee
When: Items restocked on 2/17/2022, the new visual identification system/staff education will be completed on or

183f - Discontinued Medications (continued)

before 4/30/2022 (DIRECTED: Documentation of the education shall be kept. [redacted] 4/4/22).
How: The administrator ordered new first aid kit
Ongoing: The administrator/designee will check the first aid kit at least monthly to ensure that the system is in place and that it is stocked per regulation.

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attached

184c - Sample Prescription Meds.

1. Requirements

2600.
184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

Resident #2 is prescribed [redacted] -Take 1 tablet by mouth 30 minutes before bedtime. Resident #2's [redacted] is a sample medication; however, instructions from the prescriber that include the components specified in 2600.184a were not present with the medication.

Plan of Correction ***Directed***

184.c

What: Resident #2 is ordered [redacted] - take one tab by mouth 30 minutes before bedtime. Residents [redacted] is a sample medication, the instructions from the prescriber that include the components specified in 2600.184.a were not present with the medication. The pharmacy was immediately notified, the pharmacy sent a label with components specified to regulation and was placed in bag with sample medication. An audit was performed, No other resident is prescribed medication that is a "sample"
Who: Administrator/designee
When: 2/15/2022, an audit was completed on 2/17/2022 confirming no other sample medications are ordered.
How: Administrator/designee immediately notified pharmacy for label
Ongoing: Weekly cart audits by the administrator/designee will include identification of CAM by resident including the necessary directions per regulation. The community is considering a new policy that would prohibit CAM but rather requiring any such medications to be ordered through the pharmacy.

DIRECTED: By 4/30/22: All staff persons qualified to administer medications shall be educated that sample prescription medications for all residents shall have written instructions from the prescriber that include the components specified in 2600.184a. The instructions shall be kept with the sample medications. Documentation of the education shall be kept. [redacted] 4/4/22.

184c - Sample Prescription Meds. (continued)

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attached

185a - Implement Storage Procedures

1. Requirements

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

Description of Violation

Resident #4 is prescribed blood glucose checks 4 times a day before meals and at bedtime; however, the following readings were not documented on the resident's February 2022 medication administration record (MAR):

- *2/6/22 at 3:48 pm-* [redacted]
- *2/11/22 at 7:56 am-* [redacted]

Resident #4 is prescribed blood glucose checks 4 times a day before meals and at bedtime. On 2/7/22 at 4:35 pm, the resident's blood glucose was [redacted] *however, the resident's blood glucose was documented as 98.6 on the resident's February 2022 MAR.*

Plan of Correction ***Directed***

185.a.

What: Resident #4 is prescribed blood glucose checks 4 times/day before meals and at bedtime; the reading on 2/6/2022 at 3:48 pm and 2/11/2022 at 7:56 am were not documented on the MAR. On 2/7/2022 at 4:35pm residents blood glucose was documented as a temperature. Med Tech's were trained in the Med Tech course, the Human Services Licensing Representative was still conducting the homes survey while this was being completed.
Who: Administrator/ Train the Trainer
When: 2/16/2022
How: The administrator had the date/time of education in place prior to survey being conducted. (DIRECTED: Documentation of the education shall be kept. [redacted] *4/4/22).*
Ongoing: Med Tech's: (by August 2022- UNACCEPTABLE SECTION OF PLAN OF CORRECTION LM 4/4/22). will have 2 MAR reviews, and have an observation of passing medications. (DIRECTED: By 5/15/22: Documentation of the 2 MAR reviews and 1 medication administration observation shall be kept for all staff persons qualified to administer medications. [redacted] *4/4/22). All residents glucose data will be checked at shift change by oncoming and outgoing Med Tech's. (DIRECTED: The review of all resident glucose data at change of shift shall begin on 4/7/22.* [redacted] *4/4/22). Administrator and designee will monitor Tabula Pro "SMART" dashboard for any potential missing or inaccurate data. (DIRECTED: Beginning on 4/7/22: The reviews of Tabula Pro's "SMART" dashboard shall be conducted daily*

185a - Implement Storage Procedures (continued)

for 1 month then weekly thereafter. [redacted] 4/4/22).

Completion Date: *04/01/2022*

Document Submission ***Implemented***

please see attached

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:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #3's February 2022 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- [redacted]

Resident #4's February 2022 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- [redacted]

Resident #5's February 2022 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- [redacted]

Plan of Correction ***Directed***

187.a. and 12

The home respectfully disagrees with this violation:
What: Resident #3, #4 and #5's February 2022 MAR did not include a diagnosis or purpose for numerous medications. The home was utilizing QuikMar and now utilizes Tabula Pro and Health Direct Pharmacy. When the home changed from QuikMar to Tabula Pro there was a software issue and not all diagnosis' were transferred to the MAR. The home had diagnosis' for all medications or the pharmacy would not have filled the medications. Tabula

187a - Medication Record (continued)

Pro also has a fail safe as it requires "intake" of the medication, when the medication is "intake", it requires staff to manually put in a diagnosis, if this step is not done, the medication cannot be put on the MAR. The administrator immediately notified Tabula Pro and this problem was corrected. Tabula Pro wrote a letter taking responsibility for this error and the letter was hand submitted to the Human Services Licensing Representative on 2/16/2022 by administrator. A missing diagnosis report was run the morning of 2/15/2022 and daily thereafter for 2 weeks with no other missing diagnosis' noted.
Who administrator/Tabula Pro
When: 2/15/2022
How: Administrator called Tabula Pro
Ongoing: The administrator/designee will monitor the missing diagnosis report at least weekly and this will include checking at least 10% of new orders and resident MAR's to ensure that diagnosis' are present. Please note that Tabula Pro does not allow a new order to be processed at the pharmacy without a diagnosis. This will continue for three months through 6/30/2022 or until no orders/MAR's are found to be missing a diagnosis

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review the current MAR's for residents #3, #4 and #5 to ensure a diagnosis or purpose is present for each medication. [redacted]
4/4/22

Completion Date: *04/01/2022*

Document Submission ***Implemented***

please see attached

187c - Refusal of Medication

1. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #4 refused numerous medications in February, 2022, to include the following; however, resident #4's physician was not notified of the refusals:

- [redacted]
- [redacted]
- [redacted]

187c - Refusal of Medication (continued)

- [redacted]

Plan of Correction ***Directed***

187.c
What: Resident #4 refused numerous medications in February, 2022, to include the following; however, resident #4's physician was not notified of the refusal. Staff educated on regulation 2600.187.c on 2/21/2022, (DIRECTED: Documentation of the education shall be kept. [redacted] 4/4/22). Resident #4's physician was notified of refusal of medication, no new orders received.

Who: Administrator
When: 2/21/2022
How: Verbal communication
Ongoing: Administrator/designee will audit MAR's every two weeks starting 4/02/2022 for 2 months and as needed, this will include audits of resident records to ensure physician notifications are completed.

Completion Date: *04/01/2022*

Document Submission ***Implemented***

see attached

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 [redacted] -Take by mouth 1 tablet once a day; however, this medication was not administered on [redacted], because it was not available in the home for administration.

Resident #3 is prescribe [redacted] On 2/2/22 at 4:10 pm, the resident's blood glucose was "HI" and the resident was administered 6 units of insulin. According to the manufacturer's instructions for resident #3's [redacted] a blood glucose reading of "HI" indicates the resident's blood glucose is over 600 mg/dl.

Resident #4 is prescribed blood glucose checks 4 times a day before meals and at bedtime; however, according to the resident's glucometer, the resident's blood glucose was only checked 3 times on 2/3/22, 2/11/22 and 2/14/22.

187d - Follow Prescriber's Orders (continued)

Plan of Correction ***Directed***

187.d
What: Resident #1 is prescribed Levothyroxine 50 mcg-Take by mouth 1 tablet once a day; however, this medication was not administered on 2/9/22, because it was not available in the home for administration.

Resident #3 is prescribed [redacted] *before meals in accordance with sliding scale: 250-300=4 units; 301-350=6 units; 351-400=8 units; >400=10 units. On 2/2/22 at 4:10 pm, the resident's blood glucose was "HI" and the resident was administered 6 units of insulin. According to the manufacturer's instructions for resident #3's Onetouch Verio Flex glucometer, a blood glucose reading of "HI" indicates the resident's blood glucose is over 600 mg/dl.*
Resident #4 is prescribed blood glucose checks 4 times a day before meals and at bedtime; however, according to the resident's glucometer, the resident's blood glucose was only checked 3 times on 2/3/22, 2/11/22 and 2/14/22.
Who: Administrator or designee/Train the Trainer
When: 2/16/2022,
How: All Med Tech's were re-trained in Med Tech course; surveyor was present in facility. Education was provided to Med Tech's on regulation 187.d. on 2/21/2022. (DIRECTED: Documentation of the education shall be kept. [redacted] *4/4/22). Audits will be completed every 2 weeks for 3 months to ensure medications are being given. (DIRECTED: Documentation of the audits shall be kept.* [redacted] *4/4/22).*
Ongoing: Audits will be conducted every two weeks starting 4/15/2022 x 3 months then monthly and as needed thereafter. The administrator or designee will work on a med cart at least one day weekly along with audits to ensure all medications are available in the home and to complete audits of the carts.

DIRECTED: Within 10 calendar days of receipt of the plan of correction: All staff persons qualified to administer medications shall be educated on resident glucometer readings to ensure proper understanding of glucometer readings such as "HI". The education shall include a review of all current models of glucometers currently in use and ensuring an understanding of readings such as "HI" in accordance with glucometer manufacturer instructions. The education shall also include procedures to ensure physician orders are followed for readings such as "HI", which may include additional insulin administration and notification to the prescriber. Documentation of the education shall be kept. LM 4/4/22.

DIRECTED: By 5/15/22: All Med Tech's will have 2 MAR reviews, and 1 observation of passing medications by a designated staff person. Documentation of the reviews shall be kept. [redacted] *4/4/22*
DIRECTED: Beginning on 4/7/22: All residents glucose data will be checked at shift change by oncoming and outgoing Med Tech's. [redacted] *4/4/22*
DIRECTED: Beginning on 4/7/22: Administrator and designee will monitor Tabula Pro "SMART" dashboard daily for 1 month then weekly thereafter for any potential missing or inaccurate data. [redacted] *4/4/22.*

Completion Date: *04/01/2022*

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

Document Submission ***Implemented***

see attached

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's preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank.

Resident #2's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank.

Plan of Correction ***Directed***

224.a.

Resident #1's preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank.
Resident #2's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank.
The pre admission screens for resident #1 and #2 were corrected immediately upon the finding and dated for 2/14/2022. The home can meet the residents needs. (DIRECTED: Copies of the updated preadmission screening forms for residents #1 and #2 shall be kept in their resident records. [redacted] 4/4/22).
Who: Administrator
When: 2/14/2022,
How: The boxes were written, dated and signed on [redacted] an audit was completed on [redacted] for pre screenings and all residents records are in compliance with regulation.
Ongoing: The administrator and designee (both) will review all pre screeners prior to admission to ensure all boxes are checked and for proper documentation. The community will be working with their electronic records provider to upload such resident records so that such occurrences as missing resident preadmission screening/checking box to meet need of the resident will not occur. The administrator/designee will add a reminder to the Tabula Pro calendar via the dashboard by 4/30/22. This will serve as a visual cue that the task, in this case uploading the executed resident preadmission screening for new residents. This calendar will be reviewed daily to ensure all tasks are completed in a timely manner

224a - Preadmission Screen Form (continued)

Completion Date: *04/01/2022*

Document Submission ***Implemented***

please see attached