

Department of Human Services
Bureau of Human Service Licensing

May 5, 2022

[REDACTED], ADMINISTRATOR/OWNER
[REDACTED]
[REDACTED]
[REDACTED]

RE: INDIANA SQUARE PERSONAL CARE
HOME
1703 WARREN ROAD
INDIANA, PA, 15701
LICENSE/COC#: 44744

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 02/23/2022, 02/24/2022, 02/25/2022 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
[REDACTED]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing

July 6, 2022

[REDACTED], ADMINISTRATOR/OWNER
[REDACTED]
[REDACTED]
[REDACTED]

RE: INDIANA SQUARE PERSONAL CARE
HOME
1703 WARREN ROAD
INDIANA, PA, 15701
LICENSE/COC#: 44744

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/23/2022, 02/24/2022, 02/25/2022 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: *INDIANA SQUARE PERSONAL CARE HOME* License #: *44744* License Expiration: *06/20/2022*
 Address: *1703 WARREN ROAD, INDIANA, PA 15701*
 County: *INDIANA* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

[REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *12/17/1993* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *37* Waking Staff: *28*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Complaint, Incident* Exit Conference Date: *02/25/2022*

Inspection Dates and Department Representative

02/23/2022 - On-Site: [REDACTED]
 02/24/2022 - On-Site: [REDACTED]
 02/25/2022 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* Residents Served: *22*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *16* Residents Served: *11*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *3* Are 60 Years of Age or Older: *22*
 Diagnosed with Mental Illness: *15* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *15* Have Physical Disability: *0*

Inspections / Reviews

02/23/2022 - Full

Lead Inspector: *Desmond Grace* Follow-Up Type: *POC Submission* Follow-Up Date: *03/27/2022*

Inspections / Reviews (*continued*)

04/22/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *04/29/2022*

05/03/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *05/10/2022*

05/05/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *06/10/2022*

05/06/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *06/10/2022*

06/15/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *06/17/2022*

07/05/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *07/07/2022*

07/06/2022 - 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

On [REDACTED]/22 at approximately [REDACTED] a.m., resident #1 indicated to staff person B, that when getting [REDACTED] up for the day at approximately [REDACTED] a.m., staff person A was in a very bad mood, was pushing [REDACTED] around the room and was very aggressive with [REDACTED] when [REDACTED] picked [REDACTED] up out of bed. As a result, the resident yelled out in pain and called the staff person a "bitch". Staff person A then took the resident in [REDACTED] wheelchair to [REDACTED] shared bathroom, picked [REDACTED] up, and aggressively transferred [REDACTED] onto the toilet, slamming the resident's hand on the toilet in the process. The resident sustained considerable swelling and bruising to [REDACTED] right hand and fingers. The resident indicated that the injury caused [REDACTED] pain and [REDACTED] was not able to make a fist with [REDACTED] right hand. However, the home did not report the allegation of abuse to Older Adult Protective Services until [REDACTED] 22 after [REDACTED] a.m.

Plan of Correction

Accept

On [REDACTED]/22, the facility and all of its employees have been instructed to immediately report suspected abuse of a resident being served in the home in accordance with the Older Adults Protective Services Act and comply with the requirements regarding restrictions on staff persons. The administrator, will ensure that abuse or suspected abuse is appropriately reported and investigated immediately to Area of Aging, and DHS. This administrator has implemented a written policy and procedures on [REDACTED]/22 on prevention, reporting, notification, investigation and management of reportable incidents and conditions. This administrator has educated all staff regarding the above and the time frames that must be followed. Staff will report any incident or condition to the regional office or the complaint hotline within 24 hours in a manner designated by the Department. And Area of Aging. This administrator will ensure that all staff follow the guidelines in 2600.15 in relating to abuse covered by the law. This administrator will ensure that [REDACTED] is notified immediately when any incident or condition occurs and will report to all parties immediately. Staff have also been trained on 3/16/22 on prevention of abuse and the many forms of abuse, and the proper way of reporting abuse. Staff will participate in annual training on abuse. This administrator will immediately contact AAA, DHS, and law enforcement if necessary if abuse or an incident requires within the PA 2600 Code time frames.

Completion Date: 05/04/2022

Document Submission

Implemented

Please provide documentation supporting completion of your plans of correction, i.e. pictures, education sign in sheets, tracking sheets, new policies created, etc.

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [REDACTED]/22 at approximately [REDACTED] a.m., resident #1 indicated to staff person B, that when getting [REDACTED] up for the day at approximately [REDACTED] a.m., staff person A was in a very bad mood, was pushing [REDACTED] around the room and was very aggressive with [REDACTED] when [REDACTED] picked [REDACTED] up out of bed. As a result, the resident yelled out in pain and called the staff person a "bitch". Staff person A then took the resident in [REDACTED] wheelchair to [REDACTED] shared bathroom, picked [REDACTED] up, and

42b - Abuse (continued)

aggressively transferred [redacted] onto the toilet, slamming the resident's hand on the toilet in the process. The resident sustained considerable swelling and bruising to [redacted] right hand and fingers. The resident indicated that the injury caused [redacted] pain and [redacted] was not able to make a fist with [redacted] right hand.

Plan of Correction

Accept

This administrator has implemented a written policy and procedures on prevention, reporting, notification, investigation and management of reportable incidents and conditions on 2/25/22. This is now implemented: prevention, reporting, notification, investigation, and management. A plan has been implemented by this administrator S regarding the suspension or termination of staff. This administrator has educated all staff regarding the above and the time frames that must be followed. The staff will report any incident or condition to the regional office or the complaint hotline within 24 hours in a manner designated by the Department. And Area of Aging. This administrator will ensure that all staff follow the guidelines in 2600.15 in relating to abuse covered by the law. This administrator will ensure that [redacted] is notified immediately when any incident or condition occurs and will report to all parties immediately. Staff will also be trained on an ongoing basis of prevention of abuse any the many forms of abuse, and the proper way of reporting abuse. Staff will participate in annual training on abuse. This administrator will immediately contact AAA, DHS, and law enforcement if necessary if abuse or an incident requires within the PA 2600 Code time frames. Administrator and employees will report incidents serious bodily injury or trauma requiring treatment at a medical facility, substantial risk of death, extreme pain, protracted loss or impairment of limb or organ, or other, unconsciousness, broken bones. This administrator contacted resident's doctor to order xray of [redacted] hand on [redacted] 2022, to ensure no bones were broken, POA contacted, 2/15/22, administrator and staff followed all doctor's orders. This administrator has had training regarding resident's rights, and has scheduled abuse training for all staff for 3/16/22. No types of abuse will be tolerated and all staff will be educated on all types of abuse. This administrator will monitor all residents, meet with residents, and discuss any concerns they may have regarding their care. The accused staff was terminated on [redacted] /22. This administrator will meet with the residents once a month during resident council meeting beginning in March 2022 to discuss any types of abuse/mistreatment and quality of care.

Completion Date: 05/04/2022

Document Submission

Implemented

Please provide documentation supporting completion of your plans of correction, i.e. pictures, education sign in sheets, tracking sheets, new policies created, etc.

84 - Heat Sources

1. Requirements

2600.

84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

Description of Violation

On 2/23/22, at 11:30 a.m., there were no protective guards in place to prevent residents from coming in contact with the the surface of the heating unit located on the right side hallway between resident rooms #216 and #217, posing a burn hazard. The temperature of the heating unit surface was over 150 degrees Fahrenheit.

Plan of Correction

Accept

Starting on 02/25/2022 this administrator will ensure that all heating units are properly covered with protected shields, and regular temperatures are taken if the facility were to have any of these heating sources. The administrator will maintain, along with maintenance, that there are no supplemental heating sources in the facility

84 - Heat Sources (continued)

to ensure resident's safety, keep them free from burns, and to avoid and eliminate any and all contact with any supplemental heating source whatsoever, to prevent any harm. This administrator will prohibit any supplemental heating source including such as the wall unit which was disconnected from by a certified electrician being in the facility period. The facility will depend on the main furnace as a primary heating source. A trained professional shall inspect and clean the furnace annually. Documentation of the inspection shall be kept in a binder for reference. Maintenance supervisor will maintain the log and ensure annual inspections are occurring 02/23/2022.

Completion Date: 05/04/2022

Document Submission

Implemented

Please provide documentation supporting completion of your plans of correction, i.e. pictures, education sign in sheets, tracking sheets, new policies created, etc.

92 - Windows

1. Requirements

2600.

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 2/23/22, multiple windows did not have a screen, including the left side window in resident room #116, the right side window in resident room #215, and the window in storage room #109.

Plan of Correction

Directed

The windows #116, #109, #215, have had screens placed in them by maintenance supervisor on 2/24/22. This administrator and maintenance supervisor will ensure that all windows are in good repair and securely screened.

(DIRECTED)-

Beginning on 5/6/2022-(JG) 5/5/22

Housekeeping will monitor and checks windows and screens on a daily basis, as a triple check to ensure that windows have are in good repair with no broken glass, free from splinters, or other protrusions that present a hazard. All windows that open will have screens. The left side window in resident room #116 had screen replaced, the right side window in resident room #215 and the window in storage room #109, had screens placed by maintenance supervisor. Maintenance. Administrator and, housekeeping will examine windows and screens to be in good repair and securely screened at all times.

(DIRECTED)-

By 5/10/22, all staff responsible for window screen checks and repair will be educated on §2600.92 Documentation will be submitted to the Department. [REDACTED] 5/5/22

Completion Date: 05/04/2022

Document Submission

Implemented

127a - Portable Space Heaters

1. Requirements

2600.

127.a. Portable space heaters are prohibited.

127a - Portable Space Heaters (*continued*)**Description of Violation**

On 2/23/22, at 11:55 a.m., there were three portable space heaters in the 1st floor maintenance room.

Plan of Correction**Accept**

The administrator will maintain, along with maintenance, that there are no supplemental heating sources in the facility to ensure resident's safety, keep them free from burns, and to avoid and eliminate any and all contact with any supplemental heating source. To prevent any harm. This administrator will prohibit any supplemental heating source including such as portable heaters which were discarded in dumpster and removed from the facility on 2/23/22, by maintenance supervisor. The facility will depend on the main furnace as a primary heating source. A trained professional shall inspect and clean the furnace annually. Documentation of the annual inspection shall be kept in a binder for reference. This administrator will monitor the facility starting on 2/24/22, by doing daily rounds through the facility to ensure that there are no portable space heaters on the premises at all times. This administrator has also instructed maintenance supervisor on 2/24/22, to also complete weekly walk through the facility beginning on 2/24/22, to ensure no portable space heaters are in the facility. In addition, housekeeping staff will check all resident's rooms daily, and all rooms in the facility to ensure no portable space heaters or alternative heaters are being used. Staff was trained and educated on this policy on 2/23/22.

Completion Date: 05/04/2022

Document Submission**Implemented**

Please provide documentation supporting completion of your plans of correction, i.e. pictures, education sign in sheets, tracking sheets, new policies created, etc.

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 held during the months of December 2021 and January 2022.

Plan of Correction**Directed**

This administrator has coordinated with maintenance supervisor 02/25/22, to have unannounced fire drills at least once a month on all three shifts, to have the drills unannounced drills will help ensure that staff and residents will be prepared to evacuate without hesitation in the event of a real fire. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not when resident census is low. A fire drill will be held during sleeping hours once every six months. Each fire drill will be timed to determine evacuation time by administrator, and maintenance supervisor, to ensure evacuation within the maximum evacuation time to prevent fire related death and injury. Written documentation of all fire drills will be kept in a log and maintained by this administrator, and reviewed by maintenance supervisor, at the beginning of each month. This policy will start as of 03/01/2022

(DIRECTED)-

By 5/10/22, all staff will be educated on §2600.132(a). Documentation will be submitted to the Department. ██████████

5/5/2022

Completion Date: 05/04/2022

Document Submission**Implemented**

Please provide documentation supporting completion of your plans of correction, i.e. pictures, education sign in

132a - Monthly Fire Drill (continued)

sheets, tracking sheets, new policies created, etc.

132b - Safety Inspection/Fire Drill**1. Requirements**

2600.

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

There is no documentation that a fire safety inspection and fire drill conducted by a fire safety expert was completed since 5/24/16.

Plan of Correction**Accept**

This administrator will ensure that a fire safety inspection and a fire drill conducted by a fire safety expert shall be completed annually and documentation of this fire drill and fire safety inspection be kept in a binder with this administrator. Maintenance supervisor will also be responsible to maintaining and assuring that this is scheduled annually. Facility has contacted fire safety expert to complete a fire drill and give facility the required documentation that is required PA code 2600.132 (b). This was completed on 2/28/2022. Maintenance supervisor was trained on this policy on 2/28/22 by this administrator, and by fire safety expert.

Completion Date: 05/04/2022

Document Submission**Implemented**

Please provide documentation supporting completion of your plans of correction, i.e. pictures, education sign in sheets, tracking sheets, new policies created, etc.

141b2 - Medical Evaluation Changes**1. Requirements**

2600.

141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #2's most current medication evaluation, dated [REDACTED] does not include the resident's ability to self-administer medications. This section of the form is blank.

Plan of Correction**Accept**

This administrator along with RCC has on 2/25/22, reviewed with all med techs that they must review ALL labels, and MARS, and if the resident is not indicated by a physician that they are permitted to self-medicate, they cannot self-administer any type of medications. All med techs will be trained, and aware of the residents who can self medicate. Administrator and RCC, when reviewing meds and reviewing new orders, will ensure that there are no blanks on any of the forms to avoid and eliminate errors from occurring. This Administrator, and/or RCC will complete assessments on an annual basis, and if this is a significant change, complete accurate, information that will be provided on the assessments to ensure all resident's needs can and will be met. At this point, Administrator, and RCC have reviewed and updated all assessments in accordance with PA Code 2600.141 (a) (1). Administrator, and RCC will continue to complete Pre-screen assessments, DME, RASSP, Medical Evaluation forms, and all paperwork and assessments to provide the residents with the appropriate care and treatment that is recommended and prescribed. Staff was informed that a resident who desires to self-administer medications shall be assessed by a

141b2 - Medical Evaluation Changes (continued)

physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders. PA code 2600 181c. RCC updated resident #2's DME to be accurate on 03/25/2022. RCC also began 5 additional audits of DMEs to ensure accuracy on 03/25/2022.

Completion Date: 05/04/2022

Document Submission

Implemented

Please provide documentation supporting completion of your plans of correction, i.e. pictures, education sign in sheets, tracking sheets, new policies created, etc.

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 2/24/22, [redacted] prescribed for resident #2, were in the secure dementia care unit medication cart; however, the medication was discontinued on 2/22/22.

On 2/23/22, [redacted] prescribed for resident #3 was in medication cart C; however, the medication was discontinued on 2/18/22.

Plan of Correction

Directed

The administrator, along with RCC will be completing monthly cart audits with a triple check done by RN starting on 04/26/2022. and will review with all med-techs that they must be removing and properly disposing of any D/C medications and that they must thoroughly review all charts and MARs before administering any medications and assure the proper checks of medication administration are complete. Med-techs were re-trained on D/C meds, refused meds, and expired meds on 03/25/2022. Med-techs were also reminded that only prescribed medications were allowed in the home. Med-techs were also re-trained in the proper steps in disposing of and handling medications properly for residents no longer in the home, expired medications, and D/C medications. In the event of a medication error, med-techs will report to the resident, the resident's designated person. the physician who prescribed the medication, the administrator/RCC, and the DPW within 24 hours. The med-tech will document the error and the physician's response to the error and this document must be signed by the administrator who will then review and sign the document. These changes have been implemented starting on 03/25/2022 and will continue to occur on an ongoing basis. Included in the training was proper procedure in which med-techs will contact physician/pharmacy to double check that the medication has been D/C, once they confirm the medication has been D/C 2 med-techs will observe proper destruction of the medications.

(DIRECTED)-

By 5/10/22 the discontinued medications found in the medication cart for resident #2 and resident #3 will be disposed of. Documentation will be submitted to the Department. [redacted] 5/5/2022

Completion Date: 05/04/2022

Document Submission

Implemented

The staff audited in this report are no longer employees.

187b - Date/Time of Medication Admin.

1. Requirements

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

2600.

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

Description of Violation

Resident #3 is prescribed [REDACTED] -Take one tablet by mouth every other day. The resident's medication administration record (MAR) indicates the medication was administered on 2/12/22, 2/14/22, 2/16/22, 2/18/22, and 2/22/22 at 9:00 a.m.; however, the medication was not available in the home.

Plan of Correction**Accept**

In the event of a medication error, med-techs will report to the resident, the resident's designated person, the physician who prescribed the medication, the administrator/RCC, and the DPW within 24 hours. The med-tech will document the error and the physician's response to the error and this document must be signed by the administrator who will then review and sign the document. Administrator and RCC will begin a missing medication investigation process, upon discovery of a missing medication it should be reported to the administrator immediately. Med-techs should check the pharmacy delivery slips and pharmacy should verify the delivery was made. Administrator/RCC set up auto-refills through the pharmacy on 03/25/2022. Staff re-education was also completed on 03/25/2022 to refresh med-techs on the proper policy and procedure which was implemented on 03/25/2022 for when a medication is not available in the home. Acquire enough medication from pharmacy to ensure a lapse in dosing does not occur. If there is suspicion of theft or criminal activity by any staff member, a police report should be filed. Med-techs are responsible for making sure only current medications are listed on the MAR. The administrator, RCC, and med-techs will ensure MAR accuracy by minimizing the chances of documentation mistakes when a resident refuses medication. Will continue to follow 2600.187(b).

Completion Date: 05/04/2022

Document Submission**Implemented**

The staff audited in this report are no longer employed at the facility.

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 #1 is prescribed [REDACTED] -Take one tablet by mouth daily at bedtime. On multiple dates, including 2/1/22, 2/3/22, 2/5/22, 2/6/22, 2/8/22, and 2/10/22, at 9:00 p.m., the resident refused to take the medication; however, the resident's refusal is not documented on [REDACTED] February 2022 MAR).

Plan of Correction**Accept**

If a resident refuses a medication, med-tech will make a second offering at a later appropriate time. Med-techs must report refused medications to the prescriber and document the refusal in the patient record. Teaching the value of compliance should be made while maintaining dignity and respect. Staff training on proper steps to take when a medication is refused was completed on 03/25/2022 this is also when administrator and RCC created policy regarding proper steps to take when a refusal occurs. Medication refusals will also be reported to the administrator and RCC to avoid ongoing issues or patterns. In addition, if a resident refuses to take a prescribed medication the refusal should be documented in the patient record and medication record. The refusal should be reported to the prescribing physician within 24 hours. Subsequent refusals to take prescribed medications should be reported as

187c - Refusal of Medication (continued)

required by the prescriber. The administrator and RCC will keep documentation of notification of the resident's refusal to take medication and the prescriber's response to ensure resident safety and to avoid any health complications. Med-techs have been educated and re-trained on the fact that they must document all events, including refusals, even if the medication was refused or not passed for some other reason and are actively applying this skill to all of their med passes on 03/25/2022.

Completion Date: 05/04/2022

Document Submission

Implemented

The staff audited in this report are no longer employed in this facility.

187d - Follow Prescriber's Orders

1. Requirements

2600.

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

Description of Violation

Resident #3 is prescribed [redacted] -Take one tablet by mouth every other day; however, from 2/1/22 to 2/23/22 the medication was not administered to the resident because it was not available in the home.

Plan of Correction

Directed

The med-techs shall follow the directions of the prescriber. In addition, they will follow the direction of a prescribed treatment, such as the use of medical equipment or therapy. The administrator and RCC will monitor all of the prescribed treatments/medications to ensure that residents receive medications and treatments as ordered by the physician to ensure safety and welfare of all residents on a daily/ongoing basis. In the event of a medication error, med-techs will report to the resident, the resident's designated person, the physician who prescribed the medication, the administrator/RCC, and the DPW within 24 hours. The med-tech will document the error and the physician's response to the error and this document must be signed by the administrator who will then review and sign the document. Administrator discussed with pharmacy on 03/25/2022 regarding auto-refills for medications.

(DIRECTED)-

Beginning on 5/6/22-[redacted] 5/5/22

Administrator and RCC will complete monthly med-cart audits with a triple check completed by RN. These audits will occur every month, RCC will also observe when pharmacy is in the home to complete their own audits.

(DIRECTED)-

By 5/10/22, all staff qualified to administer medication will be educated on §2600.187(d). Documentation will be submitted to the Department. [redacted] 5/5/22

Completion Date: 05/04/2022

Document Submission

Implemented

The staff audited in this report are no longer employed at this facility.

225c - Additional Assessment

1. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

- 2. If the condition of the resident significantly changes prior to the annual assessment.

225c - Additional Assessment (*continued*)**Description of Violation**

Resident #4's most recent assessment, dated [REDACTED], does not include an assessment of the resident's need for securing health care. This area of the form is blank.

Plan of Correction**Accept**

This Administrator and/or RCC will complete assessments on an annual basis, and if this is a significant change, complete accurate, information that will be provided on the assessments to ensure all resident's needs can and will be met. At this point, Administrator, and RCC have reviewed and updated all assessments in accordance with PA Code 2600.141 (a) (1). Administrator and RCC will continue to complete Pre-screen assessments, DME, RASSP, Medical Evaluation forms, and all paperwork and assessments to provide the residents with the appropriate care and treatment that is recommended and prescribed. Administrator and RCC, will ensure that assessments are reviewed with the residents, signed by the residents, reviewed by a physician, and also signed by a physician all within the regulated timeframes. This administrator will ensure this is completed immediately. 03/18/22, and on an ongoing basis. RCC completed additional audits on 5 other residents to assure RASPs were accurate, up-to-date, and completely filled out. RCC informed and educated on proper completing of RASPs on 03/25/2022. Resident #4's RASP was updated by RCC on 04/26/2022 and completed fully and properly.

Completion Date: 05/04/2022

Document Submission**Implemented**

Please provide documentation supporting completion of your plans of correction, i.e. pictures, education sign in sheets, tracking sheets, new policies created, etc.