Department of Human Services
Bureau of Human Service Licensing

August 15, 2022

, ADMINISTRATOR

RE: ARDEN COURTS (OLD ORCHARD)
4098 FREEMANSBURG AVENUE
EASTON, PA, 18045
LICENSE/COC#: 22604

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/01/2022, 03/02/2022, 03/03/2022, 03/08/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

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: *ARDEN COURTS (OLD ORCHARD)* **License #**: *22604* **License Expiration**: *01/17/2023*

Address: *4098 FREEMANSBURG AVENUE, EASTON, PA 18045*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *OLD ORCHARD HEALTH CARE CENTER - EASTON PA LLC*

Certificate(s) of Occupancy

Type: *Other* **Date**: *10/15/2015* **Issued By**: *Bethlehem Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *101* **Waking Staff**: *76*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/08/2022*

Inspection Dates and Department Representative

03/01/2022 - On-Site:
03/02/2022 - On-Site:
03/03/2022 - Off-Site:
03/08/2022 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *64*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire bhilding* **Capacity**: *64* **Residents Served**: *37*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *37*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *37* **Have Physical Disability**: *1*

Inspections / Reviews

03/01/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/02/2022*

04/26/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/06/2022*

06/16/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/14/2022*

08/15/2022 - Document Submission

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

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

Two medication errors were discovered during the home's annual inspection, involving Resident #1 and Resident #3 respectively. The home's Administrator was notified of these medication errors. These medication errors were required to be reported to DHS within 24 hours. The home has not submitted an incident report for the two medication errors.

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

• The medication errors for Resident #1 and Resident #3 were reported to DHS on March 31, 2022, by the Executive Director.
See attached Reportables.
• The Executive Director was in-serviced by the Manager of Dementia Services regarding regulation 16.c. on March 24, 2022, of the need to report incidents and conditions 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.
See attached Staff Development Program Attendance Record.
• Reportable Incidents will be reviewed at The Quarterly Management Meeting for compliance. Quarterly Management Meeting minutes will be maintained in the community and be available for the Department's review.
See attached Quality Management Plan Meeting calendar.

Completion Date: *03/31/2022*

Update: *04/26/2022*

What is the process for catching and reporting all 19 events that are reportable and the home's plan to report them timely? Who will oversee this process? Does this plan address a process to capture events at night, on the weekends and on holidays?

4-26-22

Plan of Correction ***Accept***

What is the process for catching and reporting all 19 events that are reportable and the home's plan to report them timely? Who will oversee this process? Does this plan address a process to capture events at night, on the weekends and on holidays?

4-26-22

16.c. Please see below Policy and Procedures for Reportable Incidents and Conditions which is the process for catching and reporting mandated events.
? In section B, it is noted: "Staff will report all of the following incidents and conditions to the Executive Director or designee immediately."
The 19 mandated reported events are included in the policy. Timeframe – "report immediately" – there are no
• exceptions noted re. nights, weekends, nor holidays.
? In section C, it is noted: "The home (Executive Director or designee) shall report the incident or condition to the Department's
personal home regional office or the personal care home complaint hotline within 24 hours in a manner

16c - Written Incident Report (continued)

designated by the Department."

The Executive Director or designee is noted as the individual to oversee the process re. reporting/notification, investigation, and management.

Policy:

Following are the procedures to prevent report, notify, investigate, and manage reportable incidents and conditions. (In accordance to Pa. Code §2600.16b-f.)
Procedures:
A. Prevention - All staff will follow established Department of Public Welfare and HCR ManorCare procedures to decrease the possibility of reportable incidents and conditions such as: adhering to resident's rights and following medication, resident abuse, and fire safety procedures.
B. Reporting – Reportable incidents and conditions will be reported to the Department of Public Welfare in the following manner. Staff will report all of the following incidents and conditions to the Executive Director or designee immediately.
Types of Reportable Incidents and Conditions
1. The death of a resident.
2. A physical act by a resident to commit suicide.
3. A serious bodily injury, illness or trauma requiring treatment at a hospital or medical facility.
This does not include minor injuries such as sprains or minor cuts.
Exception: "Serious bodily injury or trauma" is such that the individual experienced one or more of the following as a result of the injury:
• Substantial risk of death
• Extreme physical pain
• Protracted lost or impairment of the function of a limb, organ, or other bodily member
• Protracted unconsciousness
• Significant or substantial internal damage (such as broken bones)
Only injuries of this type need to be reported.
4. Violation of a resident's rights in § 2600.41-44.
5. An unexplained absence of a resident for 24 hours or more, or when the support plan so provides, a period of less than 24 hours, or an absence of a resident from a secured dementia care unit.
Exception: This does not include a resident who wanders outside without leaving the premises (property of the home) and is immediately guided back inside by staff.
6. Misuse of resident funds by the home's staff persons or legal entity.
7. An outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2
(relating to specific identified reportable diseases, infections, and conditions). See
Appendix C for a list of communicable diseases.
8. Food poisoning of residents.
9. A physical or sexual assault resident to resident or against a resident.
10. Fire or structural damage to the home.
11. An incident requiring the services of an emergency management agency, fire department or law enforcement agency, except for false alarms.

16c - Written Incident Report (continued)

Exception: This does not include:
• Calls to an ambulance/EMS.
• A police response to a 302 involuntary commitment proceeding.
• Police response to an EMS call.
• A response to a false alarm, such as a system malfunction or accidental sounding of the alarm. Minor events that trigger a fire department response (such as burned popcorn) must be reported.
12. A complaint of resident abuse, suspected resident abuse or referral of a complaint of a resident abuse to a local authority.
13. A prescription medication error as defined in § 2600.188 (relating to medication errors).
14. An emergency in which procedures under § 2600.107 (relating to emergency preparedness) are implemented.
15. An unscheduled closure of the home or relocation of the residents.
16. Bankruptcy filed by the legal entity.
17. A criminal conviction against the legal entity, administrator or staff that are subsequent to the reporting on the criminal history checks under § 2600.51 (relating to criminal history checks).
18. A termination notice from a utility company. This includes a termination notice or an actual service termination.
19. A violation of applicable health and safety laws listed in § 2600.12 (relating to applicable health and safety laws).
C. Reporting/Notification
1. The home (Executive Director or designee) shall report the incident or condition to the Department's personal 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).
2. In addition to completion of the written forms, the following incidents must also be reported by telephone by the Executive Director or designee to the Department's personal care home regional office or via the ARL complaint hotline within 24 hours, except for the exclusions listed above:
? Unexpected death of a resident
? An unexplained absence of a resident for 24 hours or more or any absence of a resident from a secured dementia unit.
? Fire or structural damage to the home making it uninhabitable overnight.
? An emergency in which the procedures under § 2600.107 (relating to emergency preparedness) are implemented.
? An unscheduled closure of the home or relocation of the residents for any reason.
? Termination of water or electricity, or termination of heat for any reason resulting in temperature in any area of the home falling below 70 degrees for more than two hours.
Telephone reports must include: the date and time of the report, the name of the home, the home's full address, the type of incident, a brief description of the incident and the name and phone number of the person making the report.
3. This is the initial incident/condition report. The home shall submit a final report to the Department's personal care home regional office immediately following the conclusion of the home's investigation per the procedures under § 2600.16d.
A final report is required when the incident or condition described in the initial report requires additional investigation by the home, or if the home did not have enough information to submit a comprehensive report when the incident initially occurred. The final report need not be submitted on a specific form, but must include the home's name, license number, and the date and time the initial report was submitted to the Department.
D. Investigation
1. The investigation will be completed by the Executive Director or designee following Department

16c - Written Incident Report (continued)

and HCR ManorCare procedures.

2. If the home's final report validates the occurrence of the alleged incident or condition, the affected resident or other residents who could potentially be harmed or his designated person shall also be informed immediately following the conclusion of the investigation by the Executive Director or designee.

E. Management
1. The home shall keep a copy of the report of the reportable incident or condition in the residents' record.
2. Reportable incidents must be reviewed in aggregate as part of the home's quality management process.
Contact Numbers
Department of Public Welfare
Attn: Regional Licensing Representative

Completion Date: *05/23/2022*

Document Submission ***Implemented***

What is the process for catching and reporting all 19 events that are reportable and the home's plan to report them timely? Who will oversee this process? Does this plan address a process to capture events at night, on the weekends and on holidays?

AG, 4-26-22

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B. Reporting – Reportable incidents and conditions will be reported to the Department of Public Welfare in the

16c - Written Incident Report (continued)

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Types of Reportable Incidents and Conditions

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3. A serious bodily injury, illness or trauma requiring treatment at a hospital or medical facility.

This does not include minor injuries such as sprains or minor cuts.

Exception: "Serious bodily injury or trauma" is such that the individual experienced one or more of the following as a result of the injury:

• Substantial risk of death

• Extreme physical pain

• Protracted lost or impairment of the function of a limb, organ, or other bodily member

• Protracted unconsciousness

• Significant or substantial internal damage (such as broken bones)

Only injuries of this type need to be reported.

4. Violation of a resident's rights in § 2600.41-44.

5. An unexplained absence of a resident for 24 hours or more, or when the support plan so provides, a period of less than 24 hours, or an absence of a resident from a secured dementia care unit.

Exception: This does not include a resident who wanders outside without leaving the premises (property of the home) and is immediately guided back inside by staff.

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7. An outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2
(relating to specific identified reportable diseases, infections, and conditions). See
Appendix C for a list of communicable diseases.

8. Food poisoning of residents.

9. A physical or sexual assault resident to resident or against a resident.

10. Fire or structural damage to the home.

11. An incident requiring the services of an emergency management agency, fire department or law enforcement agency, except for false alarms.

Exception: This does not include:

• Calls to an ambulance/EMS.

• A police response to a 302 involuntary commitment proceeding.

• Police response to an EMS call.

• A response to a false alarm, such as a system malfunction or accidental sounding of the alarm. Minor events that trigger a fire department response (such as burned popcorn) must be reported.

12. A complaint of resident abuse, suspected resident abuse or referral of a complaint of a resident abuse to a local authority.

13. A prescription medication error as defined in § 2600.188 (relating to medication errors).

14. An emergency in which procedures under § 2600.107 (relating to emergency preparedness) are implemented.

15. An unscheduled closure of the home or relocation of the residents.

16. Bankruptcy filed by the legal entity.

17. A criminal conviction against the legal entity, administrator or staff that are subsequent to the reporting on the criminal history checks under § 2600.51 (relating to criminal history checks).

18. A termination notice from a utility company. This includes a termination notice or an actual service termination.

16c - Written Incident Report (continued)

19. A violation of applicable health and safety laws listed in § 2600.12 (relating to applicable health and safety laws).
C. Reporting/Notification
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2. In addition to completion of the written forms, the following incidents must also be reported by telephone by the Executive Director or designee to the Department's personal care home regional office or via the ARL complaint hotline within 24 hours, except for the exclusions listed above:
? Unexpected death of a resident
? An unexplained absence of a resident for 24 hours or more or any absence of a resident from a secured dementia unit.
? Fire or structural damage to the home making it uninhabitable overnight.
? An emergency in which the procedures under § 2600.107 (relating to emergency preparedness) are implemented.
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Telephone reports must include: the date and time of the report, the name of the home, the home's full address, the type of incident, a brief description of the incident and the name and phone number of the person making the report.
3. This is the initial incident/condition report. The home shall submit a final report to the Department's personal care home regional office immediately following the conclusion of the home's investigation per the procedures under § 2600.16d.
A final report is required when the incident or condition described in the initial report requires additional investigation by the home, or if the home did not have enough information to submit a comprehensive report when the incident initially occurred. The final report need not be submitted on a specific form, but must include the home's name, license number, and the date and time the initial report was submitted to the Department.
D. Investigation
1. The investigation will be completed by the Executive Director or designee following Department and HCR ManorCare procedures.
2. If the home's final report validates the occurrence of the alleged incident or condition, the affected resident or other residents who could potentially be harmed or his designated person shall also be informed immediately following the conclusion of the investigation by the Executive Director or designee.
E. Management
1. The home shall keep a copy of the report of the reportable incident or condition in the residents' record.
2. Reportable incidents must be reviewed in aggregate as part of the home's quality management process.
Contact Numbers
Department of Public Welfare
Attn: Regional Licensing Representative

26a - Quality Management Plan

1. Requirements

2600.

26a - Quality Management Plan *(continued)*

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

Description of Violation

Per the home's Quality Management Plan, the home conducts quality management meetings quarterly. The most recent quality management meeting was conducted 10/21/2021. The home has not been following their plan to conduct meetings quarterly.

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

• The Quality Management Plan Meeting for fourth quarter 2021 (October, November, December 2021) was held on March 10, 2022.
See attached document (minutes).
• The coordinators were in-serviced by the Manager of Dementia Services on March 10, 2022, concerning regulation 26.a. re. Quality Management Plan requirements.
See attached Staff Development Program Attendance Record.
• Quarterly Management Meeting minutes will be maintained in the community and be available for the Department's review. The Quality Management Plan Meeting calendar for 2021-2023 has been created.
See attached Quality Management Plan Meeting calendar.

Completion Date: *03/31/2022*

Update: *04/26/2022*

who will be responsible for compliance going forward?

█ 4-26-22

Plan of Correction ***Accept***

who will be responsible for compliance going forward?

█, 4-26-22
26.a. Please see below Quality Management Policy.
? As starred in the policy, the Executive Director is the designated plan manager; therefore, will be responsible for compliance going forward.

Arden Courts/Linden Village

Quality Management Plan

Pursuant to its authority derived from s.2600.26, PENNSYLVANIA STATUTES, and as part of its quality assurance administrative function, Arden Courts/Linden Village (the "Facility") has established a Quality Management Plan. The program includes, but is not limited to, implementing procedures regarding the following:
A designated manager to oversee the quality management plan. The
****Executive Director is the designated plan manager.****
Investigation and analysis of frequency and causes of general categories and specific types of reportable incidents and conditions.
Analysis of complaints that relate to the quality and delivery of resident services.
Review of scheduling and tracking of staff person training.
Evaluate deficiencies cited by the Department of Public Welfare with the development of Plans of Correction.
Occurrence of resident or family councils, or both, if applicable.

26a - Quality Management Plan (continued)

A written summary of the previous items will be completed quarterly.
This summary will include: date of the review, who conducted the review,
how the review was done, findings, development of plans to respond to and
correct deficiencies.

Completion Date: *05/23/2022*

Document Submission ***Implemented***

who will be responsible for compliance going forward?

█, 4-26-22
26.a. Please see below Quality Management Policy.
? As starred in the policy, the Executive Director is the designated plan manager; therefore, will be responsible for compliance going forward.

Arden Courts/Linden Village

Quality Management Plan

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A designated manager to oversee the quality management plan. The
****Executive Director is the designated plan manager.****
Investigation and analysis of frequency and causes of general categories and specific types of reportable incidents and conditions.
Analysis of complaints that relate to the quality and delivery of resident services.
Review of scheduling and tracking of staff person training.
Evaluate deficiencies cited by the Department of Public Welfare with the development of Plans of Correction.
Occurrence of resident or family councils, or both, if applicable.
A written summary of the previous items will be completed quarterly.
This summary will include: date of the review, who conducted the review,
how the review was done, findings, development of plans to respond to and
correct deficiencies.

82c - Locking Poisonous Materials

1. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

A spray bottle of Peroxide Multi Surface Disinfectant, with a manufacture's label indicating "If swallowed call poison control or doctor for treatment", was unlocked, unattended, and accessible to residents. The residents of the home have been assessed as not capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Plan of Correction ***Accept***

• The Peroxide Multi Surface Disinfectant was immediately stored in a locked area.
• The Building Services Coordinator (BSC) and housekeepers were in-serviced by the Manager of Dementia Services on March 10, 2022, concerning regulation 82.c. re. proper storage of poisonous materials and addition of "Storage of poisonous materials" to the Resident Room Deep Cleaning Checklist.
See attached Staff Development Program Attendance Record.
• Housekeepers will monitor for proper storage of poisonous materials via documentation on the Resident Room Deep Cleaning Checklist. The BSC will conduct random checks to ensure compliance. Time frame-April 1, 2022 through June 30, 2022. The Resident Room Deep Cleaning Checklist will be maintained in the community and be available for the Department's review.
See attached Resident Room Deep Cleaning Checklist

Completion Date: *03/31/2022*

Update: *04/26/2022*

Please go into the Portal and review the information and submit the verifications or evidence of compliance for your plan and submit via the Sans Write Portal to complete Step 2. That will then allow me to complete your renewal/investigation process.

Please send in completed documents for the deep cleaning examples in order for your verification to be accepted.

█ *4-26-22*

Document Submission ***Implemented***

• The Peroxide Multi Surface Disinfectant was immediately stored in a locked area.
• The Building Services Coordinator (BSC) and housekeepers were in-serviced by the Manager of Dementia Services on March 10, 2022, concerning regulation 82.c. re. proper storage of poisonous materials and addition of "Storage of poisonous materials" to the Resident Room Deep Cleaning Checklist.
See attached Staff Development Program Attendance Record.
• Housekeepers will monitor for proper storage of poisonous materials via documentation on the Resident Room Deep Cleaning Checklist. The BSC will conduct random checks to ensure compliance. Time frame-April 1, 2022 through June 30, 2022. The Resident Room Deep Cleaning Checklist will be maintained in the community and be available for the Department's review.
See attached Resident Room Deep Cleaning Checklist

103i - Outdated Food

1. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was a container of Yoplait strawberry yogurt in the refrigerator located in the home's Berry Ridge section with an expiration date of 1/10/2022. This product was expired at time of inspection.

103i - Outdated Food *(continued)*

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

• The expired yogurt was discarded immediately.
• The Coordinators and Cook were in-serviced by the Manager of Dementia Services on March 10, 2022, concerning regulation 103.i. re. outdated or spoiled foods or dented cans may not be used and addition of "No outdated/spoiled food" added to Dining Room Observation Tool.
See attached Staff Development Program Attendance Record.
• Coordinators and Cook will monitor for outdated/spoiled food via documentation on the Dining Room Observation Tool. The Tool will be utilized two (2) times per week to ensure compliance.
Time frame-April 1, 2022 through June 30, 2022. The Dining Room Observation Tool will be maintained in the community and be available for the Department's review.
See attached Dining Room Observation Tool.

Completion Date: *03/31/2022*

Update: *04/26/2022*

Who will be responsible for compliance?

Please go into the Portal and review the information and submit the verifications or evidence of compliance for your plan and submit via the Sans Write Portal to complete Step 2. That will then allow me to complete your renewal/investigation process.

Please end in evidence of compliance by documenting completed Dining Room Observation Tool use.

4-26-22

Plan of Correction ***Accept***

Who will be responsible for compliance?

Please go into the Portal and review the information and submit the verifications or evidence of compliance for your plan and submit via the Sans Write Portal to complete Step 2. That will then allow me to complete your renewal/investigation process.

Please end in evidence of compliance by documenting completed Dining Room Observation Tool use.

4-26-22
103.i. Please see attached current Dining Room Observation Tool (with the following documented review).
? The Executive Director will be responsible for compliance via. reviewing the Dining Room Observation Tools weekly. Proof of review will include documented
initials and date on the Dining Room Observation Tool.

Completion Date: *05/23/2022*

Document Submission ***Implemented***

Who will be responsible for compliance?

Please go into the Portal and review the information and submit the verifications or evidence of compliance for

103i - Outdated Food (continued)

your plan and submit via the Sans Write Portal to complete Step 2. That will then allow me to complete your renewal/investigation process.

Please end in evidence of compliance by documenting completed Dining Room Observation Tool use.

██, 4-26-22
103.i. Please see attached current Dining Room Observation Tool (with the following documented review).
? The Executive Director will be responsible for compliance via. reviewing the Dining Room Observation Tools weekly. Proof of review will include documented
initials and date on the Dining Room Observation Tool.

132c - Fire Drill Records

1. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill on 1/30/2022 states it was conducted at "1:50" and does not indicate AM or PM.

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

• A notation was added to fire drill (1/30/2022) re. am/pm with a late entry noted See attached document.
• The Building Services Coordinator was in-serviced by the Manager of Dementia Services on March 10, 2022, concerning regulation 132.c. re. documentation of fire drills. See attached Staff Development Program Attendance Record.
• Fire drills will be reviewed at the Quarterly Management Meeting for compliance.
• Quarterly Management Meeting minutes will be maintained in the community and be available for the Department’s review. The Quality Management Plan Meeting calendar for 2021-2023 has been created. See attached Quality Management Plan Meeting calendar.

Completion Date: *03/31/2022*

Update: *04/26/2022*

Who will oversee compliance going forward?

Please send in a current copy of the home's Fire Drill Log as evidence of compliance for Step 2.

██, 4-26-22

Plan of Correction ***Accept***

Who will oversee compliance going forward?

Please send in a current copy of the home's Fire Drill Log as evidence of compliance for Step 2.

132c - Fire Drill Records (continued)

███, *4-26-22*

132.c. Please see attached current Fire Drill Log (with the following documented review as evidence of compliance).
? The Executive Director will review the Fire Drills monthly to ensure compliance going forward. Proof of review will include documented initials and date on the Fire Drill Log.

Completion Date: *05/23/2022*

Document Submission ***Implemented***

Who will oversee compliance going forward?

Please send in a current copy of the home's Fire Drill Log as evidence of compliance for Step 2.

███, *4-26-22*

132.c. Please see attached current Fire Drill Log (with the following documented review as evidence of compliance).
? The Executive Director will review the Fire Drills monthly to ensure compliance going forward. Proof of review will include documented initials and date on the Fire Drill Log.

144b - Policy on Smoking

1. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

Resident #2's resident-home contract states that smoking is not permitted under the section labeled "House Rules." However, Addendum D of the contract, labeled "Smoking Policy and Procedures" states that residents are permitted to smoke. The home's home rules also state that residents are permitted to smoke. The home's smoking policy is inconsistent and must be updated.

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

• The coordinators were in-serviced by the Manager of Dementia Services on March 31, 2022, concerning regulation 144.b. re. revised Resident Policy on Smoking.
See attached Staff Development Program Attendance Record.
• The Resident House Rules and Addendum D were revised on March 30, 2022, to reflect a Resident No Smoking Policy.
See attached revised House Rules and Addendum D.
• The revised Resident Addendum D re. No Resident Smoking Policy was mailed to Resident POA's and hand-delivered to residents on March 31, 2022 by the Executive Director and Administrative Services.
See attached letter

Completion Date: *03/31/2022*

Update: *04/26/2022*

Who will be responsible for ongoing compliance? Is someone tracking all responses received and checking to

144b - Policy on Smoking (continued)

see that all contracts will be updated?

Who will ensure future compliance?

█, 4-26-22

Plan of Correction ***Accept***

Who will be responsible for ongoing compliance? Is someone tracking all responses received and checking to see that all contracts will be updated?

Who will ensure future compliance?

144.b. The Executive Director is responsible for on-going/future compliance.
? The revised Smoking Policy was effective 5/1/2022. Per feedback from the Coordinators to the Executive Director, there have been no negative responses from
POA's nor residents concerning the revised Smoking Policy.
? The Executive Director will be responsible to ensure that all contracts will be the updated version. Process will include checking the contract for compliance before initiation with the
the reviewing/signing process.

█ 4-26-22

Completion Date: *05/23/2022*

Document Submission ***Implemented***

Who will be responsible for ongoing compliance? Is someone tracking all responses received and checking to see that all contracts will be updated?

Who will ensure future compliance?

144.b. The Executive Director is responsible for on-going/future compliance.
? The revised Smoking Policy was effective 5/1/2022. Per feedback from the Coordinators to the Executive Director, there have been no negative responses from
POA's nor residents concerning the revised Smoking Policy.
? The Executive Director will be responsible to ensure that all contracts will be the updated version. Process will include checking the contract for compliance before initiation with the
the reviewing/signing process.

█ 4-26-22

144b - Policy on Smoking (continued)

162c - Menus Posted

1. Requirements

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

Description of Violation

The home's menu for the current week and the following week were not posted. Per staff interviews, the menus that were posted in the home at time of inspection were not correct.

Plan of Correction ***Accept***

• The correct current and following week's menus have been posted by the Food Service Coordinator.
• The Coordinators and Cook were in-serviced by the Manager of Dementia Services on March 10, 2022, concerning regulation 162.c. and documentation of compliance on the revised Dining Room Observation Tool.
See attached Staff Development Program Attendance Record.
• Coordinators and Cook will monitor for "Food served – matches menu" which includes posting of current and following weeks' menus on the Dining Room Observation Tool. The Tool will be utilized two (2) times per week to ensure compliance.
Time frame-April 1, 2022 through June 30, 2022. The Dining Room Observation Tool will be maintained in the community and be available for the Department's review.
See attached Dining Room Observation Tool.

Completion Date: *03/31/2022*

Update: *04/26/2022*

Please send in a recently completed Dining Room Observation Tool document for Step 2 as evidence of compliance.

AG, 4-26-22

Document Submission ***Implemented***

• The correct current and following week's menus have been posted by the Food Service Coordinator.
• The Coordinators and Cook were in-serviced by the Manager of Dementia Services on March 10, 2022, concerning regulation 162.c. and documentation of compliance on the revised Dining Room Observation Tool.
See attached Staff Development Program Attendance Record.
• Coordinators and Cook will monitor for "Food served – matches menu" which includes posting of current and following weeks' menus on the Dining Room Observation Tool. The Tool will be utilized two (2) times per week to ensure compliance.
Time frame-April 1, 2022 through June 30, 2022. The Dining Room Observation Tool will be maintained in the community and be available for the Department's review.
See attached Dining Room Observation Tool.

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

Per the home's controlled substance policy, the oncoming and off-going medication technicians do a count of residents' narcotic medications and then sign off that the count was completed. On 3/22/2022, the first shift oncoming medication technician did not sign the "Shift Change Controlled Drug Count" sheet to indicate that the count was completed.

Plan of Correction ***Accept***

• The nurses and medication aides were in-serviced by the Mobile Resident Services Coordinator on March 2, 2022 concerning regulation 185.a. and documentation on the Shift Change Controlled Drug Count form and completion of weekly Medication Cart Audits.
See attached Staff Development Program Attendance Record.
• The Executive Director or designee will review the shift Change Controlled Drug Count form for compliance weekly as noted by documented signature and date on the Medication Cart Audit Tool. Time frame-April 1, 2022 through June 30, 2022. The Medication Cart Audits will be maintained in the community and be available for the Department's review. See attached Medication Cart Audit.

Completion Date: *03/31/2022*

Update: *04/26/2022*

Please submit recently completed Medication Cart Audit documents for review and approval in Step 2.

, 4-26-22

Document Submission ***Implemented***

• The nurses and medication aides were in-serviced by the Mobile Resident Services Coordinator on March 2, 2022 concerning regulation 185.a. and documentation on the Shift Change Controlled Drug Count form and completion of weekly Medication Cart Audits.
See attached Staff Development Program Attendance Record.
• The Executive Director or designee will review the shift Change Controlled Drug Count form for compliance weekly as noted by documented signature and date on the Medication Cart Audit Tool. Time frame-April 1, 2022 through June 30, 2022. The Medication Cart Audits will be maintained in the community and be available for the Department's review. See attached Medication Cart Audit.

187a - Medication Record

1. Requirements

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

Description of Violation

Resident #1 is prescribed . On 3/1/22 and 3/2/22, Staff Person A stated they administered this medication. Staff Person A did not sign the resident's medication record to indicate that this medication was administered and when it was administered.

Plan of Correction ***Accept***

• A Reportable was submitted to the Department on March 31, 2022 concerning the medication error re. Resident #1.

187a - Medication Record (continued)

See attached Reportable.
• The nurses and medication aides were in-serviced by the Mobile Resident Services Coordinator on March 2, 2022 concerning regulation 187.a. re. Medication Records and the weekly completion of the Medication Cart Audit.
See attached Staff Development Program Attendance Record.
• The Executive Director or designee will review the Medication Cart Audits for compliance weekly as noted by documented signature and date on the Medication Cart Audit Tool. Time frame-April 1, 2022 through June 30, 2022. The Medication Cart Audits will be maintained in the community and be available for the Department's review.
See attached Medication Cart Audit.

Completion Date: *03/31/2022*

Update: *04/26/2022*

Please send in a recently COMPLETED Medication Cart Audit form for the home's Step 2 portion.

AG, 4-26-22

Document Submission ***Implemented***

• A Reportable was submitted to the Department on March 31, 2022 concerning the medication error re. Resident #1.
See attached Reportable.
• The nurses and medication aides were in-serviced by the Mobile Resident Services Coordinator on March 2, 2022 concerning regulation 187.a. re. Medication Records and the weekly completion of the Medication Cart Audit.
See attached Staff Development Program Attendance Record.
• The Executive Director or designee will review the Medication Cart Audits for compliance weekly as noted by documented signature and date on the Medication Cart Audit Tool. Time frame-April 1, 2022 through June 30, 2022. The Medication Cart Audits will be maintained in the community and be available for the Department's review.
See attached Medication Cart Audit.

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] every 6 hours daily. In the month of February 2022, this order was incorrectly transcribed onto the resident's medication record (MAR) as an "as needed" medication. This medication was not administered as prescribed in the month of February 2022. It is also not known if the resident received this medication on 3/1/22 and 3/2/22 every 6 hours as directed, as the resident's MAR was not initialed to indicate the medication was administered.

Resident #3 is prescribed [redacted]. On 3/2/22, Resident #3 did not receive this medication due to the medication not being available. Per staff, the medication ran out that morning.

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

• Reportables were submitted to the Department on March 31, 2022 concerning the medication errors re. Resident #1 and Resident #3.
See attached Reportables.
• The nurses and medication aides were in-serviced by the Mobile Resident Services Coordinator on March 2, 2022

187d - Follow Prescriber's Orders (continued)

concerning regulation 187.d. re. following the orders of the prescriber and completion of weekly Medication Cart Audits.
See attached Staff Development Program Attendance Record.
• The physician provided clarification concerning the medication order for Resident #1.
See attached medication order for Resident #1.
• The medication for Resident #3 was requested for re-fill.
See attached request for re-fill of medication for Resident #3.
• The Executive Director or designee will review the Medication Cart Audit for compliance weekly as noted by documented signature and date on the Medication Cart Audit Tool. Time frame-April 1, 2022 through June 30, 2022.
The Medication Cart Audits will be maintained in the community and be available for the Department's review.
See attached Medication Cart Audit.

Completion Date: *03/31/2022*

Update: *04/26/2022*

Please send in a recently COMPLETED Medication Cart Audit form for the home's Step 2 portion.

Also please entail how the home anticipates fulfilling all current and future Rx and Treatment orders NOT related to the specific violations, but maintaining compliance with this regulation going forward.

█, 4-26-22

Plan of Correction ***Accept***

Please send in a recently COMPLETED Medication Cart Audit form for the home's Step 2 portion.

Also please entail how the home anticipates fulfilling all current and future Rx and Treatment orders NOT related to the specific violations, but maintaining compliance with this regulation going forward.

█ 4-26-22
187.d. Please see attached completed Medication Cart Audit.
? The Medication Cart Audits will be completed weekly going forward to ensure compliance with regulation 187.d.
? The weekly Medication Cart Audit includes:
MOR reviewed for completeness. This ensures compliance of initialing when medication is administered per prescriber's orders.
Medications available as ordered/labeled correctly (routine, PRN and over the counter medication
This ensures compliance of accurate orders/pharmacy labels and medications are available per prescriber's orders.
? The Executive Director or designee will review the weekly Medication Cart Audits, including random audits for verification per prescriber's orders,
to ensure compliance with regulation 187.d. going forward. Proof of review will include documented initials and date on the weekly Medication Cart Audits.

Completion Date: *05/23/2022*

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

Document Submission ***Implemented***

Please send in a recently COMPLETED Medication Cart Audit form for the home's Step 2 portion.

Also please entail how the home anticipates fulfilling all current and future Rx and Treatment orders NOT related to the specific violations, but maintaining compliance with this regulation going forward.

█, 4-26-22
187.d. Please see attached completed Medication Cart Audit.
? The Medication Cart Audits will be completed weekly going forward to ensure compliance with regulation 187.d.
? The weekly Medication Cart Audit includes:
MOR reviewed for completeness. This ensures compliance of initialing when medication is administered per prescriber's orders.
Medications available as ordered/labeled correctly (routine, PRN and over the counter medication
This ensures compliance of accurate orders/pharmacy labels and medications are available per prescriber's orders.
? The Executive Director or designee will review the weekly Medication Cart Audits, including random audits for verification per prescriber's orders,
to ensure compliance with regulation 187.d. going forward. Proof of review will include documented initials and date on the weekly Medication Cart Audits.