Department of Human Services
Bureau of Human Service Licensing

June 14, 2022

[redacted], CHIEF OPERATING OFFICER
[redacted]

RE: SENIOR COMMONS AT POWDER MILL
1775 POWDER MILL ROAD
YORK, PA, 17403
LICENSE/COC#: 33210

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/12/2022, 04/13/2022, 04/14/2022 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: *SENIOR COMMONS AT POWDER MILL* **License #:** *33210* **License Expiration:** *01/18/2023*

Address: *1775 POWDER MILL ROAD, YORK, PA 17403*

County: *YORK* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *GAHC3 YORK PA ALF TRS SUB LLC*

Address: *660 SENTRY PARKWAY, SUITE 220, BLUE BELL, PA, 19422*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/23/2001* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *154* **Waking Staff:** *116*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *04/14/2022*

Inspection Dates and Department Representative

04/12/2022 - On-Site: [redacted]
04/13/2022 - On-Site: [redacted]
04/14/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *166* **Residents Served:** *112*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Rosewood and Arlington Court* **Capacity:** *28* **Residents Served:** *27*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *112*

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

Have Mobility Need: *42* **Have Physical Disability:** *5*

Inspections / Reviews

04/12/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/09/2022*

05/16/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/23/2022*

05/25/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/10/2022*

06/14/2022 - Document Submission

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

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 3/27/22, from 11 PM to 7 AM, 106 residents were present in the home. During this time, only 1 staff person who was certified in first aid and CPR was present in the home.

On 3/30/22, from 11 PM to 7 AM, 109 residents were present in the home. During this time, only 2 staff persons trained and certified in first aid and CPR were present in the home.

Plan of Correction ***Accept***

What: On 4/12/22, during the annual survey it was identified that on 3/27/22 from 11PM to 7AM, 106 residents were present in the home. During this time, only (1) staff person who was certified in first aid and CPR was present in the home.
On 3/30/22, from 11PM to 7AM, 109 residents were present in the home. During this time, only 2 staff persons trained and certified in first aid and CPR were present in the home.
Who: The Resident Care Director will use the Clinical Audit Tool – Attachment B. To track adequate staff is 1st aid and CPR trained to meet the required resident to staff ratio on each shift. Sign in sheet Attachment C to verify team members who attended class. Copies of first aid & CPR cards to be kept in employee file. Business Office will keep 1stAid & CPR Binder to keep all staff 1st Aid/CPR information in one location.
When: Staff 1st aid & CPR training scheduled for 05/27/22
How: Business Office Director will audit employee files (2) per month (starting on 6/1/22) to track first aid and CPR certifications are current.
Ongoing: Bi-annual first aid & CPR training will be held for current team members and new hires. First aid and CPR audit tracking tool ATTACHMENT B will be completed (monthly) to track that staff are up to date. Sign in sheet ATTACHMENT C will be used track attendance at first aid and CPR trainings.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps are ongoing with new team members coming onboard for training.

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 the morning of 4/12/22, the floor at the exit door located at the bottom of the steps from the second floor, near Room 201, had an accumulation of dried mud, plant debris, leaves, dirt, cobwebs and dead insects. In addition, there was an accumulation of dried leaves, dirt, a dirty mask, and discarded silk flowers at the exterior door leading to the boiler room.

88a - Surfaces *(continued)*

Plan of Correction ***Accept***

What: On 04/12/2022 during the annual survey, it was identified that the floor at the exit door located at the bottom of the steps from the second floor, near room 201, had an accumulation of dried mud, plant debris, leaves, dirt, cobwebs and dead insects. In addition, there was an accumulation of dried leaves dirt, a dirty mask, and discarded silk flowers at the exterior door leading to the boiler room.
Who: The Maintenance Director will train the Managers, Housekeeping, and Maintenance Departments on Plan of Correction-Environmental Conditions of Surfaces (Attachment E) and complete training Sign-in Sheet (Attachment F).
When: Area cleaned of debris on 4/12/22. Surface regulation training will be completed by 5/30/22.
How: The Maintenance Director will complete weekly audit of Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards throughout the building and the exterior exit pathways starting on 4/19/2022.
Ongoing: The Maintenance Director will conduct a weekly community wide audit (Starting on 4/19/2022) for surfaces to be clean, in good repair and free of hazards while documenting on Plan of Correction-Environmental Conditions of Surfaces (Attachment E) Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps in Process

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 records for drills conducted on 12/10/21, 1/26/22, 2/15/22 and 3/22/22 do not have the exit route(s) that were used during the drills identified. The location of the simulated fire is recorded in place of the exit route(s) used. In addition, the number of residents evacuated is incorrectly recorded, showing only the number of residents that were in the affected area at the time of the drill, and not the number of residents participating in the evacuation.

Plan of Correction ***Accept***

What: On 4/12/22, during the annual survey, it was noted that the fire drill records for drills conducted on 12/10/21, 1/26/22, 2/15/22 and 3/22/22 do not have the exit route(s) that were used during the drills identified. The location of the simulated fire is recorded in place of the exit route(s) used. In addition, the number of residents evacuated is incorrectly recorded, showing only the number of residents that were in the affected area at the time of the drill, and not the number of residents participating in the evacuation.
Who: The Maintenance Director will utilize the Adult Residential Licensing – Personal Care Home Fire Drill Log (ATTACHMENT H) to follow and record each monthly fire drill. The Maintenance Director, or Designee will be sure to identify the exit routes the location of the simulated fire and the total number (of residents in the community) evacuated during the simulation.

132c - Fire Drill Records (continued)

When: Maintenance Director will utilize Adult Residential Licensing – Personal Care Home Fire Drill Log (Attachment H) starting on 5-10-22 fire drill. Maintenance Director will note specific exit route and full number of residents evacuated
How: Maintenance Director will discuss with Executive Director planned location of fire drill simulation. Maintenance Director will obtain full in community census prior to the drill from the Executive Director, the location of the simulated fire will be agreed and planned by the Maintenance Director and Executive Director and the evacuation routes will be agreed and planned by the Maintenance Director and Executive Director, prior to each monthly drill. The drill will continue to remain a surprise to the staff and residents.
Ongoing: The Maintenance Director and Executive Director will each sign off using (ATTACHMENT I) that the fire drill plan was reviewed prior to the simulated drill and after the drill was conducted to track accuracy of reported information and that the community was successfully evacuating all residents from the community, not just the residents in the area affected by the fire.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps are in progress

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 week of 4/10/22 through 4/16/22 was posted however, the following week's menu was not posted.

Plan of Correction ***Accept***

What: On 4/12/22, during the annual survey it was identified that the home's menu for the week of 4/10/22 through 4/16/22 was posted, however the following weeks menu was not posted.
Who: The Dining Services Director will develop a monthly (4) week rotation menu for residents and use Menu Posting Sign off form (ATTACHMENT K) to track home is posting menu (2) weeks in advance in conspicuous location, visible to all residents.
When: Two weeks of menu's posted on 4-12-2022
How: Dining Services Director will audit menu postings every week (Monday mornings, beginning 5/23/22) to ensure two weeks of menus are posted. Findings will be discussed at the quarterly Q/A meeting
Ongoing: Dining Service Director will sign off on Menu Posting Sign off form (ATTACHMENT K) each Monday morning to confirm menu has been added to conspicuous location and residents are able to see offerings two weeks in advance of meal at all times.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps in Process

183b - Meds and Syringes Locked

1. Requirements

183b - Meds and Syringes Locked *(continued)*

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 4/13/22 at 2:30 PM, a small, round, white pill, identified as Furosemide, was found on the hallway floor by the door to Room #508.

Plan of Correction ***Accept***

What: On 4/13/22 at 2:30pm during the annual survey, a small, round, white pill, identified as Furosemide, was found on the hallway floor by the door to room #508

Who: The Resident Care Director will train all staff on Medication Cart audit education (Attachment M) to confirm all prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked.
When: Training to be completed by 5/30/22 and will include education on safe medication storage in resident rooms for those that self-administers.
How: Resident Care Director will use Medication Cart Audit form (Attachment N) to ensure medications are locked in the cart
Ongoing: Medication carts will be audited by clinical leadership team using Medication Cart Audit Form (Attachment N) weekly. Weekly audit of each cart (beginning 5/23/22) will be checked off using Medication Cart Audit weekly tracker (Attachment B) to confirm each cart has medications properly locked away.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps in progress

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

The following blood glucose levels for Resident #7 were not correctly recorded on the resident's medication administration record (MAR):

Date and Time	*Glucometer Reading*	*MAR*
4/2/22 11 AM	[redacted]	
4/13/22 11 AM		

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept***

What: The home shall ensure the residents' glucometers match the readings documented on the residents' medication administration records. During annual survey inspection on 04/12/22, the following blood glucose levels for Resident #7 were not correctly recorded on the resident's medication administration record (MAR):
Date & Time Glucometer Reading MAR

[redacted]

Who: The Clinical leadership team will audit (1) resident weekly to confirm blood sugars are accurately logged using the blood sugar confirmation log (ATTACHMENT P) and calibrate glucometers for date and time weekly to track accuracy.
When: The Clinical leadership team will complete audits of blood sugars and glucometers weekly on Mondays starting on 5/30/22.
How: The Clinical leadership team, will audit the glucometer audit and blood sugar confirmation logs on a weekly basis and will be reported on during quarterly Q/A meetings.
Ongoing: To track quality, the Clinical leadership team will sign off they are accurately logged by auditing (ATTACHMENT P) blood sugar confirmation log for (1) resident, weekly.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps in progress

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).

De

Th *not list the diagnosis or purpose for the following*
m *edication in the field for diagnosis.*

[redacted]

Th *6 includes the medications, Albuterol nebulizer and*
Lor *ribed for this resident.*

Plan of Correction ***Accept***

What: On 04/12/2022 during the annual survey, it was identified that the medication administration record (MAR) for Resident #5 does not list the diagnosis or purpose for the following medications as it lists another name or

187a

agnosis.

[redacted]

for Resident #6 includes the medications, albuterol nebulizer and are not prescribed for this resident.

Med Techs and Clinical Leadership team and use complete Sign-in Sheet (Attachment R) on Order approval process (Attachment S) and confirm at shift change all medications have diagnosis using Med Tech Shift Change responsibility (Attachment T).

When: Training to be completed by 5/30/22

How: The Med Techs and Clinical Leadership team will assure all medications have diagnosis listed by auditing (1) chart weekly and signing off on the Weekly Clinical Audit Tool (Attachment B).

Ongoing: Beginning 5/23/22, the Resident Care Director and Memory Care Director will conduct a random weekly audit of 2 residents (MAR) to assure all medications have a diagnosis to accompany that medication and document on Weekly Clinical Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps in progress

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 was admitted to the home on [redacted] *however, the resident's preadmission screening form was completed on 5/27/21.*

Plan of Correction ***Accept***

What: On 4/12/22 during the annual survey, it was identified that resident #1 was admitted to the home on 5/26/21; however, the resident's preadmission screening form was completed on [redacted]

Who: The Resident Care Director (RCD) and Memory Care Director (MCD) will train the Med Techs and Clinical Leadership team on 30-day Chart Audit tool (Attachment V) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment W).

When: Training to be completed by 5/30/22

How: The Clinical Leadership team will assure prescreens include a determination that the home can meet the needs of the resident by the services provided, prior to admission to SCDU.

224a - Preadmission Screen Form (continued)

Ongoing: The Resident Care Director and Memory Care Director will complete a weekly audit of preadmission screen forms (Starting on 5/30/22) for all residents who moved into the community that week and document on Clinical Audit Tool Weekly (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps in progress

225a - Assessment 15 Days

1. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #2 who was admitted to the home on [redacted] has a Resident Assessment and Support Plan (RASP) with an assessment completion date of [redacted] however, the assessment sections were not completed and are blank.

Resident #3 was admitted to the home on [redacted] however, the initial assessment for Resident #3 was completed on [redacted]

Plan of Correction ***Accept***

What: On 4/12/22 during the annual survey it was noted that Resident #2 (who was admitted to the home on 7/29/21) has a Resident Assessment and Support Plan (RASP) with an assessment completion date of [redacted] however, the assessment sections were not completed and are blank.
Resident #3 was admitted to the home on [redacted] however, the initial assessment for resident #3 was completed on 2/18/22.
Who: The Resident Care Director and Memory Care Director will train the Med Techs and Clinical Leadership team on 30-day Chart Audit tool (Attachment V) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment W) following training.
When: Training to be completed by 5/30/22
How: The Clinical Leadership team will assure a new resident assessment is completed timely after admission.
Ongoing: The Resident Care Director and Memory Care Director will conduct an audit of all residents who were admitted in the last week (every Monday starting on 5/30/22) to make sure their assessment has been completed in 15 days for Personal Care and 72 hours for Memory Care residents and document on Clinical Audit Tool Weekly (Attachment B). Findings and trends will be reviewed at the quarterly QA meetings.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps in progress

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.

Description of Violation

Resident #4 experienced a significant change in condition which is documented by a medical evaluation, dated [redacted] Resident #4 was diagnosed with Covid-19, pneumonia due to Covid-19 and debility due to Covid-19 pneumonia. Physical therapy, occupational therapy and monitoring of respirator status were ordered as a result of these new diagnoses. The RASP, completed on [redacted] was not updated to reflect the change in condition and needs, nor was a new RASP completed.

Resident #9 had a medical evaluation, completed on [redacted] which indicated a significant change. The medical evaluation documented that the resident is not able to self administer medications, is prescribed a mechanical soft diet with ground meats and is moderately immobile. The RASP completed on [redacted] was not updated to reflect these needs nor was a new RASP completed.

Plan of Correction ***Accept***

What: On 04/12/2022 during the annual survey, it was identified that Resident #4 experienced a significant change in condition which is documented by a medical evaluation, dated [redacted] Resident #4 was diagnosed with Covid-19, pneumonia due to Covid-19 and debility due to Covid-19 pneumonia. Physical therapy, occupational therapy and monitoring of respirator status were ordered as a result of these new diagnoses. The RASP, completed on [redacted] was not updated to reflect the change in condition and needs, nor was a new RASP completed.
Resident #9 had a medical evaluation, completed on [redacted] which indicated a significant change. The medical evaluation documented that the resident is not able to self-administer medications, is prescribed a mechanical soft diet with ground meats and is moderately immobile. The RASP completed on [redacted] was not updated to reflect these needs nor was a new RASP completed
Who: The Resident Care Director and Memory Care Director will train the Med Techs and Clinical Leadership team on 30-day Chart Audit tool (Attachment V) and Clinical Audit Tool Weekly (Attachment B) and complete Sign-in Sheet (Attachment W) following training.
When: Training to be completed by 5/30/22
How: The Clinical Leadership team will assure a new resident assessment is completed timely when a resident has a significant change.
Ongoing: The Resident Care Director and Memory Care Director will conduct a weekly audit (starting on 5/30/22) of all residents who had a significate change that week and have a new assessment and document on Weekly Clinical Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps are in progress

227a - Support Plan 30 Days

1. Requirements

2600.

227a - Support Plan 30 Days *(continued)*

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #2 who was admitted on [redacted] does not have a completed support plan.
Resident #3 who was admitted on [redacted] does not have a completed support plan.

Plan of Correction ***Accept***

What: On 4/12/22 during the annual survey, it was identified that Resident #2 who was admitted on [redacted] does not have a completed support plan and Resident #3 who was admitted on [redacted] does not have a completed support plan.
Who: The Resident Care Director and Memory Care Director will use Weekly Clinical Audit Tool (Attachment B) to track new residents support plans are being completed. In addition, The Resident Care Director, Memory Care Director or Designee will use the 30-day chart audit tool (Attachment V) to confirm all resident support plans are completed. Clinical Audit tool and 30-day chart audit tool training to be completed for clinical leadership team Sign in sheet (attachment W).
When: Training completed by 5/30/22
How: The Clinical Leadership team will confirm resident support plans are completed that have missing fields or are not completed
Ongoing: The Resident Care Director and Memory Care Director will utilize the 30-day chart audit tool (Attachment V) to confirm resident support plans are completed within 30-days of admission to community (starting on 5/30/22). Clinical leadership team will audit (1) current resident chart weekly using the 30-day chart audit tool (Attachment V) in order to confirm resident support plans are completed. Findings and trends will be reviewed at the quarterly QA Meeting

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps are in progress

227d - Support Plan Medical/Dental

1. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #10 has an enabler bar attached to their bed. The RASP for Resident #10 does not address the need for the enabler bar, that the resident has been educated in the risk associated with having the device attached to their bed or the plan to keep the resident safe while using the enabler bar.

Plan of Correction ***Accept***

What: On 4/12/22 during the annual survey, Resident #10 was noted to have an enabler bar attached to their bed.

227d - Support Plan Medical/Dental (continued)

The rasp for Resident #10 does not address the need for the enabler bar, that the resident has been educated in the risk associated with having the device attached to their bed or the plan to keep the resident safe while using the enabler bar
Who: The Resident Care Director and Memory Care Director will train the clinical leadership team on what to look for when entering a resident's room and reporting back if an enabler bar has been placed on the bed. The Clinical Leadership team will use Room inspection checklist (Attachment BB) to ensure residents have been properly educated on enabler bar safety. Clinical leadership team will use Clinical Audit Tool (Attachment B) during weekly audit and staff will complete Sign-in Sheet (Attachment CC) upon completion of enabler bar education training.
When: Training to be completed by 5/30/22
How: The Clinical Leadership team will confirm resident assessments are completed and address need for enabler bars and risk education associated with device.
Ongoing: The Resident Care Director and Memory Care Director will conduct a weekly audit (starting on 5/30/2022) of all residents who had a new enabler bar need and document on Enabler Bar audit checklist (Attachment JJ). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Steps are in progress

231c - Preadmission Screening

1. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] *However, the resident's written cognitive preadmission screening was completed on* [redacted]

Plan of Correction ***Accept***

What: On 4/12/2022, during the annual survey, it was identified that Resident #1 was admitted to the SDCU on [redacted] *However, the preadmission screening was completed on* [redacted]
Who: The Memory Care Director will confirm residents who move in to the SDCU will have a completed preadmission screening 72 hours prior to move in to the SDCU by using the New MOVE IN checklist (Attachment FF)
When: New move in tracker (Attachment FF) implemented on 4/15/2022
How: The Memory Care Director will assure when a resident moves into our Daybreak Neighborhood the prescreen is completed 72 hours prior to admission.
Ongoing: The Memory Care Director will conduct a weekly meeting with the admission team (starting on 4/15/22) to confirm the team is prepared for the new resident and the prescreen is completed at least 72 hours prior to admission to the SDCU. Clinical leadership team will use New Move in Tracker (Attachment FF) to confirm that the prescreen is completed at least 72 hours prior to admission to SDCU. Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/22/2022*

231c - Preadmission Screening *(continued)*

Document Submission ***Implemented***

Steps in Process

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] at approximately 9 PM, Staff Person A was assisting Resident #8 in preparing for bed. Resident #8 was resistant to changing into pajamas. Staff person A became forceful in assisting the resident, resulting in the resident sustaining two skin tears, one to the right lower arm and one to the upper left arm, from the staff person's fingernails digging into their skin.

Repeated Violation - 5/06/2020, et al

Plan of Correction ***Accept***

What: On [redacted] at approximately 9:00pm, staff person A was assisting resident #8 in preparing for bed. Resident #8 was resistant to changing into pajamas. Staff person A became forceful in assisting the resident, resulting in the resident sustaining two skin tears, one to the right lower arm and one to the upper left arm, from the staff person's fingernails digging into their skin.

Who: Staff person A was suspended as soon as the Resident Care Director became aware of the incident the morning of [redacted] and placed on leave while the investigation into the incident was ongoing. DHS reportable completed and submitted on [redacted] and AAA Act 13 completed and submitted on [redacted] Investigation completed on [redacted] Staff person A did not return to community until [redacted]
When: Employee terminated on [redacted] after investigation was completed.
How: Annual training of staff to confirm understanding of Resident Rights (ATTACHMENT HH). New hires to complete all mandatory trainings prior to working with residents (ATTACHMENT II).
Ongoing: Resident Care Director will review trainings in a quarterly basis, beginning 5/30/22, to discuss trends and track all staff are up to date on resident's rights trainings. Quarterly review of incidents and training. Per regulation and best practice, we will continue to review training status and incidents at quarterly QA Meeting.

Completion Date: *05/22/2022*

Document Submission ***Implemented***

Plan completed and ongoing with new hire training/annual training