



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: November 8, 2022

[REDACTED]
Walden's View North Huntingdon Opco LLC
7990 U.S. Route 30
North Huntingdon, Pennsylvania 15642

RE: Walden's View at North Huntingdon
License/COC #: 446802

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on April 12, 2022, April 13, 2022, July 18, 2022, July 19, 2022, and July 20, 2022, of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from November 8, 2022 to May 8, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
Section:					
51	II	79	\$5	\$395	5 calendar days from mailing date of this letter
81(b)	II	79	\$5	\$395	5 calendar days from mailing date of this letter
85(a)	II	79	\$5	\$395	5 calendar days from mailing date of this letter
101(j)(7)	II	79	\$5	\$395	5 calendar days from mailing date of this letter
144(c)(2)	II	79	\$5	\$395	5 calendar days from mailing date of this letter
183(b)	II	79	\$5	\$395	5 calendar days from mailing date of this letter
187(d)	II	79	\$5	\$395	5 calendar days from mailing date of this letter
225(a)	II	79	\$5	\$395	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]
[REDACTED]
[REDACTED]

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

Facility Information

Name: WALDEN'S VIEW AT NORTH HUNTINGDON License #: 44680 License Expiration: 10/05/2022
Address: 7990 US ROUTE 30, NORTH HUNTINGDON, PA 15642
County: WESTMORELAND Region: WESTERN

Administrator

Name: [REDACTED] Phone: 7248632600 Email: [REDACTED]

Legal Entity

Name: WALDEN'S VIEW NORTH HUNTINGDON OPCO LLC
Address: 7990 ROUTE 30, NORTH HUNTINGDON, PA, 15642
Phone: 7248632600 Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 08/19/2002 Issued By: Labor and Industry

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 106 Waking Staff: 80

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint Exit Conference Date: 05/06/2022

Inspection Dates and Department Representative

04/12/2022 - On-Site: [REDACTED]
04/13/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 100 Residents Served: 83

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 9

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 82
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 1
Have Mobility Need: 23 Have Physical Disability: 1

Inspections / Reviews

04/12/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/19/2022

Inspections / Reviews (*continued*)

05/25/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *06/01/2022*

06/02/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *06/03/2022*

06/03/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *07/01/2022*

10/14/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

Follow-Up Date:

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

Beginning in January 2022, multiple staff persons have overheard staff person A verbally abuse resident #6 by calling [redacted] names; however, these instances of verbal abuse were not reported to the local Area Agency on Aging.

Plan of Correction

Directed

Immediately on 4/13/22 alleged abuse that occurred on 4/13/22 was reported to the area on aging orally on 4/13/22 @ 4:00 pm and the written report at 5:00 pm , BHSL notified on 4/14/22 @ 1:00 pm. All staff re-educated on the importance of reporting any abuse to administration immediately on 5/13/22. (DIRECTED: Documentation of education shall be kept. [redacted] 6/1/22)

To maintain continued compliance with proper abuse reporting, the assistant administrator put a list of all reportable incidents (2600.16) and Walden's View policy is posted at the wellness room, breakroom and by the time clock. The administrator, assistance administrator, resident care coordinators and any medtech will be responsible to report abuse immediately following Walden's View policy, all management has the capability to report abuse off site. If there is a report of any alleged abuse, immediate re-training of all staff will occur within 72hours from when the report is made, Walden's View will also implement mandatory abuse training quarterly to ensure understanding of the importance of abuse and abuse reporting. (see attached documentation)

Assistant Administrator and on call supervisor will do daily walk thru at a mealtime. Ensuring that every resident is free of abuse/neglect. If any issues arise, an immediate report and investigation will ensue. This will be monitored with proper documentation (see attached document).

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review all internal incidents and conditions daily to ensure any allegations of abuse or neglect are reported timely to the Area Agency on Aging in accordance with the Older Adult Protective Services Act. [redacted] 6/1/22 [redacted] 0/14/22

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

Not Implemented

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

Beginning in January 2022, multiple staff persons have overheard staff person A verbally abuse resident #6 by calling [redacted] names; however, these instances of verbal abuse were not reported to the Department.

Plan of Correction

Directed

Immediately on 4/13/22 alleged abuse that occurred on 4/13/22 was reported to the area on aging orally on 4/13/22 @ 4:00 pm and the written report at 5:00 pm , BHSL notified on 4/14/22 @ 1:00 pm. All staff re-educated on the importance of reporting any abuse to administration immediately on 5/13/22. (DIRECTED: Documentation of the education shall be kept. [redacted] 6/1/22).

To maintain continued compliance with proper abuse reporting, the assistant administrator put a list of all

16c - Written Incident Report (continued)

reportable incidents (2600.16) and Walden's View policy is posted at the wellness room, breakroom and by the time clock. The administrator, assistance administrator, resident care coordinators and any medtech will be responsible to report abuse immediately following Walden's View policy, all management has the capability to report abuse off site. If there is a report of any alleged abuse, immediate re-training of all staff will occur within 72hours from when the report is made, Walden's View will also implement mandatory abuse training quarterly to ensure understanding of the importance of abuse and abuse reporting. (see attached documentation)

Assistant Administrator and on call supervisor will do daily walk thru at a mealtime. Ensuring that every resident is free of abuse/neglect. If any issues arise, an immediate report and investigation will ensue. This will be monitored with proper documentation (see attached document).

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review all internal incidents and conditions daily to ensure all incidents and conditions indicated in 2600.16a are reported to the Department within 24 hours. [REDACTED] 6/1/22 [REDACTED] 10/14/22

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation **Not Implemented**

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

Beginning in January 2022, multiple staff persons overheard staff person A call resident #6 a "[REDACTED]" and a "[REDACTED]". Resident #6 has asked staff person A to stop calling him names on numerous occasions; however, staff person A continues to call him names. Resident #6 indicated he gets very upset when staff person A calls him names. Multiple staff persons indicated resident #6 complains to them about being called names by staff person A, and resident #6 often cries when talking about the instances of verbal abuse from staff person A.

Plan of Correction

Directed

Staff person A was immediately terminated via telephone from employment on [REDACTED] Area on aging, POA and BHSL notified of alleged abuse on 4/13/22. All staff educated on mandatory abuse training and reporting on 5/13/22. (see attached documentation). [REDACTED] from AAA completed the abuse/neglect and mandatory reporting training. Also, this training will be in every new hire packet. (DIRECTED: Documentation of the training conducted by the Area Agency on Aging shall be kept. [REDACTED] 6/2/22). RCC, [REDACTED] will go over each page with new employee and will be signed by RCC and new hire.

To maintain compliance with proper abuse reporting a list of all reportable incidents (2600.16) and Walden's View policy is posted at the wellness room, breakroom and by the time clock. The administrator, assistance administrator, resident care coordinators and any med techs will be responsible to report abuse immediately following Walden's View policy, all management has the capability to report abuse off site. If there is a report of any alleged abuse, immediate re-training of all staff will occur within 72hours from when the report is made, Walden's View will also implement mandatory abuse training quarterly for all departments on specific duties and responsibilities to ensure understanding of the importance of abuse and abuse reporting. The administrator or designee will interview at least 3 residents and 3 staff persons regarding care and treatment, including with incontinence care monthly. (DIRECTED: The resident/staff interviews shall begin within 5 calendar days of receipt of the plan of correction. Documentation

42b - Abuse (continued)

of the interviews shall be kept. [REDACTED] 6/2/22). The administrator or designee will increase supervision of direct care staff to ensure they are adequately assisting residents in a manner that's compliant; This will include weekly unannounced evening care observations, with assistance if needed, of direct care staff performing care to residents.

A staff meeting was held 5/26/2022 to ensure all employees are aware and completely understand the importance of mandatory report and resident's rights. (See attached document)

Caring hospice RN will be doing resident rights training on 5/31/2022. (See attached document). (DIRECTED: Documentation of training shall be kept. [REDACTED] 6/2/22).

7/1/2022 A quality management meeting will be held to review all plan of correction and evaluation of its function and ensure it is being properly completed. Documentation to follow on 7/1/2022. (DIRECTED: During the home's quality management review, the administrator will place an increased emphasis on these plans of correction and take action to improve the quality of its resident rights and Older Adult Protective Services Act (OAPSA) training for all newly hired staff within 40 scheduled working hours in accordance with §2600.65(b)(1) and §2600.65(b)(3) and annually in accordance with §2600.65(g)(3) and §2600.65(g)(4). Documentation of the quality management review shall be kept. [REDACTED] 6/2/22).

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

Not [REDACTED] 10/14/22
emented

60a - Staff/Support Plan

1. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 3/31/22, there were 80 residents in the home, including 20 residents with mobility needs. Of the 20 residents with mobility needs, 4 residents require the assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift.

On 4/2/22, there were 80 residents in the home, including 20 residents with mobility needs. Of the 20 residents with mobility needs, 4 residents require the assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift.

On 4/9/22, there were 78 residents in the home, including 19 residents with mobility needs. Of the 19 residents with mobility needs, 4 residents require the assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift.

On 3/31/22, 4/2/22 and 4/9/22, only 3 staff persons were present in the home from 11:00 PM through 7:00 AM, which is not adequate to safely evacuate all residents in an emergency. The home does not currently have a maximum fire-safe evacuation time in writing within the past year by a fire safety expert that exceeds 2 minutes, 30 seconds.

Plan of Correction

Directed

Immediately an additional staff member was added to the 11p-7a shift on 5/10/2022 to equal a total of 4 staff

60a - Staff/Support Plan (continued)

members on that shift. In order to stay in compliance if there would be a call off for that shift coverage will be found or a member of the management team will cover the shift in order to maintain compliance.

RCC, [redacted] and on call supervisor will monitor schedule daily by using assignment sheet to ensure every need is met. (See attached document)

Administrator and assistant administrator will approve the schedule, ensuring that all required shifts are filled before schedule is posted

DIRECTED: Within 30 days of receipt of the plan of correction: The home shall conduct an unannounced fire drill with 4 staff members to ensure all residents are able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. If all residents are unable to evacuate within the time specified in writing within the past year by a fire safety expert, immediate remedial action shall occur, which may include scheduling additional staff persons, and conducting an additional fire drill within 5 calendar days. Documentation of all fire drills shall be kept. [redacted] 6/2/22

[redacted] 10/14/22

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

Not Implemented

88a - Surfaces

1. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 4/12/22, an approximate 1' x 1' area of what appears to be black mold was present on the ceiling in the shower in bedroom [redacted]

On 4/12/22, an approximate 1' x 1.5' area of peeling paint and water damage is present on the ceiling of the shower in bedroom [redacted]

Plan of Correction

Directed

Immediately on 4/12/2022 the black mold in [redacted] was addressed along with the peeling paint in [redacted] On 4/13/2022 all bathrooms within the facility were checked by maintenance and any problem areas were addressed. To stay in compliance monthly maintenance walkthroughs will be done in any area within the facility that contains moisture to be inspected and any issues will be handled immediately. (DIRECTED: The monthly maintenance walkthroughs shall begin within 5 days of receipt of the plan of correction. [redacted] 6/1/22).

Housekeeping staff will have a meeting on 5/31/2022 at 10:00 am. This meeting will educate on what to look for and a group for Maintenance has been added to the communication app for the Walden's view campus for all housekeeping to report any concerns. (See attached document). (DIRECTED: Documentation of the education shall be kept. [redacted] 6/1/22).

Housekeeping reporting any issues started on 4/13/2022

88a - Surfaces (continued)

10/14/22

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

Not Implemented

123d - Mobility Needs

1. Requirements

2600.

123.d. If the home serves one or more residents with mobility needs above or below grade level of the home, there shall be a fire-safe area, as specified in writing within the past year by a fire safety expert, on the same floor as each resident with mobility needs.

Description of Violation

The 3rd floor of the home is above grade level and serves numerous residents with mobility needs, including resident #2; however, the 3rd floor of the home does not have a fire-safe area specified in writing within the past year by a fire safety expert.

Plan of Correction

Accept

Immediately on 4/13/22 staff spoke with assistance fire chief from Straw pump VFD and scheduled full evacuation on 4/15/22 the time to evacuate is and is in writing (please see attached documentation) Monthly fire drills will be done and staff will evacuate within the written time given to meet the mobility needs of the residents. All floors have fire safe doors on each wing. Each wing is a fire safe area for evacuation of the residents. Documentation of this is on the current full evacuation.

According to documentation from the fire safety expert, dated 4/13/22, the stairwells on the east and west wings on all floors are fire-safe areas. 6/3/22

10/14/22

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

Implemented

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

The most recent fire safety inspection and fire drill conducted by a fire safety expert was completed on 4/15/22; however, the previous fire safety inspection and fire drill conducted by a fire safety expert was completed on 6/12/19.

Plan of Correction

Accept

Immediately on 4/13/22 staff spoke with assistance fire chief from strawpump VFD and scheduled full evacuation on 4/15/22 the time to evacuate is 12 minutes and is in writing (please see attached documentation) Monthly fire drills will be done and staff will evacuate within the written time given to meet the mobility needs of the residents. Maintenance staff was reeducated on proper documentation when conducting fire drills. The assistant administrator will be present and review documentation following all fire drills to ensure documentation is correct.

132b - Safety Inspection/Fire Drill (continued)

Admin/assist admin with monitor monthly and yearly that Maintenance is conducting monthly unannounced fire drills. Also, will monitor maintenance with yearly inspection/drill with a fire safe expert.

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

0/14/22
Implemented

132d - Evacuation

1. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill that was conducted on 12/30/21 at 10:44 AM, 80 residents were present in the home; however, only 15 residents were evacuated.

During the fire drill that was conducted on 1/26/22 at 3:22 PM, 81 residents were present in the home; however, only 1 resident was evacuated.

During the fire drill that was conducted on 2/24/22 at 5:09 AM, 89 residents were present in the home; however, no residents were evacuated.

During the fire drill that was conducted on 3/10/22 at 3:45 PM, 85 residents were present in the home; however, no residents were evacuated.

Plan of Correction

Directed

Immediately on 4/13/22 staff spoke with assistance fire chief from strawpump VFD and scheduled full evacuation on 4/15/22 the time to evacuate is 12 minutes and is in writing (please see attached documentation) Monthly fire drills will be done and staff will evacuate within the written time given to meet the mobility needs of the residents. Maintenance staff was reeducated on proper documentation when conducting fire drills. The assistant administrator will be present and review documentation following all fire drills to ensure documentation is correct.

Resident council meeting happens monthly. At Each council meeting we will reeducate residents about the importance of fire drills and why they are mandatory. This will be done by assist admin and/or activity director. The education occurred 4/18/2022 (see attached document)

DIRECTED: Within 10 calendar days of receipt of the plan of correction: All staff persons shall be reeducated on the home's fire drill evacuation procedures and the location of all fire-safe areas to ensure all residents are able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. Documentation of the education shall be kept. 6/1/22

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

10/14/22
Not Implemented

141a - Medical Evaluation

1. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #1's medical evaluation, dated [REDACTED] is not signed by the medical professional who completed the evaluation. This section of the evaluation is blank.

Resident #7's medical evaluation, dated [REDACTED] is not signed by the medical professional who completed the evaluation and does not include the medical professional license number of the medical professional who completed the evaluation. These sections of the evaluation are blank.

Plan of Correction**Directed**

Immediately training was set up with caring hospice to review and re-educate administrator, assistant administrator and resident care coordinators on filling out DME and support plans accurately and timely for 5/31/2022. A complete facility chart audit will be conducted and completed by 5/31/2022 to ensure all DME's are signed by a licensed physician. A designated person will complete monthly chart audits. Chart audits began 5/1/2022. (See attached document) All charts will be audited monthly.

Residents #1 and #7 were corrected the day of inspection 4/13/2022.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure a medial evaluation is completed in its entirety for each newly-admitted resident within 60 days prior to admission or within 30 days after admission. Copies of the completed new admission checklist shall be kept in each resident's record. [REDACTED] 6/2/22.

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

[REDACTED] 10/14/22

Document Submission**Implemented**

Immediately training was set up with caring hospice to review and re-educate administrator, assistant administrator and resident care coordinators on filling out DME and support plans accurately and timely for 5/31/2022. A complete facility chart audit will be conducted and completed by 5/31/2022 to ensure all DME's are signed by a licensed physician. A designated person will complete monthly chart audits. Chart audits began 5/1/2022. (See attached document) All charts will be audited monthly.

Residents #1 and #7 were corrected the day of inspection 4/13/2022.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure a medial evaluation is completed in its entirety for each newly-admitted resident within 60 days prior to admission or within 30 days after admission. Copies of the completed new admission checklist shall be kept in each resident's record. [REDACTED] 6/2/22.

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.

185a - Implement Storage Procedures (continued)

Description of Violation

Resident #4 is prescribed blood sugar checks twice daily before AM and PM meals; however, numerous blood sugar checks were not documented on resident #4's April 2022 medication administration record (MAR), to include the following:

- AM blood sugar reading on 4/9/22
- PM blood sugar readings on 4/1/22, 4/2/22, 4/4/22, 4/6/22, 4/7/22 and 4/8/22

Resident #4 is prescribed blood sugar checks twice daily before AM and PM meals. On 4/1/22 at 9:49 AM, resident #4's blood sugar was [REDACTED] however, was documented as [REDACTED] on resident #4's April 2022 MAR. On 4/2/22 at 9:45 AM, resident #4's blood sugar [REDACTED]; however, was documented as 127 on resident #4's April 2022 MAR.

Plan of Correction**Directed**

Immediately a training for all med techs for diabetic training will be held on 5/24/2022. (DIRECTED: Documentation of the education shall be kept. [REDACTED] 6/1/22).

A designated staff member will do weekly glucose audits to ensure the values match in the MAR and glucose meter. Audits started on 4/20/2022 and all residents that are prescribed BS checks will be included in the audit. (See attached document) (DIRECTED: Documentation of the audits shall be kept. [REDACTED] 6/1/22).

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

Not [REDACTED] 10/14/22 ented

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 #2 is prescribed Polyethylene Glycol-Take 17 grams by mouth daily as needed for [REDACTED] however, this medication is not present on resident #2's April 2022 MAR.

Resident #3 was prescribed Amlodipine 5 mg-Take 1 tablet by mouth once a day and Carvedilol 6.25 mg-Take 1 tablet by mouth twice a day. These medications were previously discontinued; however, are still present on resident #3's April 2022 MAR.

Plan of Correction**Directed**

Hospice RN ordered resident #2's medication from an outside pharmacy. All hospice agencies have been directed to utilize facility pharmacies for all medications on 4/21/2022, unless emergent need for end-of-life medication is needed. All orders from outside agencies will be reviewed by RCC as ordered. (Per discussion with provider on 6/2/22, resident #2's Polyethylene Glycol was to the resident's MAR on 4/13/22. [REDACTED] 6/2/22).

Resident #3 was readmitted to the facility after [REDACTED] and deciding to return long term, all medications were duplicated by the pharmacy. While the inspector was on site [REDACTED] pharmacy wrote a letter stating the error that occurred. No medication was given twice. The MAR of all readmissions will be reviewed by RCC. (Per discussion with provider on 6/2/22, resident #3's Amlodipine 5 mg and Carvedilol 6.25 mg were re-ordered and delivered to the home on 4/13/22. [REDACTED] 6/2/22).

187a - Medication Record (continued)

As of 5/1/2022 all chart started to get audited. All charts have been audited for the month of May. Assistant administrator and a designated med tech will review each chart monthly. The review will ensure that there is a current face sheet, Updated DME that is signed by MD and has licensing number, updated RASP that has proper signature, proper date, proper diet, correct mobility needs. (DIRECTED: Within 7 calendar days of receipt of the plan of correction, then monthly thereafter: A designated staff person shall review the current MAR's for all residents to ensure accuracy and completeness in accordance with prescribers' orders. [redacted] 6/1/22). Management meeting will occur Monday, Wednesday and Friday morning every week and a review will be done on any significant changes. Also, a home health/hospice meeting occurs every Thursday and this will also be reviewed then. Assistant administrator will do all updates.

DIRECTED: Within 10 calendar days of receipt of the plan of correction: All staff persons qualified to administer medications shall be reeducated on the home's medication procedures, including procedures for immediately updating resident MAR's upon receipt of new or change orders issued by the residents' prescriber. Documentation of the education shall be kept. [redacted] 6/1/22

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

[redacted] 10/14/22

Not Implemented

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #4 is prescribed blood sugar checks twice daily before AM and PM meals; however, resident #4's blood sugar was not tested at all on 4/5/22 and was only tested in the evening on 4/10/22.

Resident #9 was prescribed Breo Elipta 200-25MG-Inhale 1 inhalation orally once a day, rinse mouth and expectorate after each use; however, this medication was not administered to resident #9 from approximately 1/22/22 through 4/6/22, because it was not available in the home for administration. The medication was discontinued on 4/6/22.

Resident #9 is prescribed Carvedilol 6.25 mg-Take 1 tablet by mouth twice a day; however this medication was not administered to resident #9 from approximately 1/22/22 through 3/20/22, because it was not available in the home for administration.

Resident #9 is prescribed Ezetimibe 10 mg-Take 1 tablet by mouth once a day; however, this medication was not administered to resident #9 from approximately 1/22/22 through 3/3/22, because it was not available in the home for administration.

Resident #9 is prescribed Ferrous Sulfate 325 mg-Take 1 tablet by mouth once a day; however this medication was not administered to resident #9 from approximately 1/22/22 through 4/11/22, because it was not available in the home for administration.

Resident #9 is prescribed Lovastatin 10 mg-Take 1 tablet by mouth once a day; however, this medication was not

187d - Follow Prescriber's Orders (continued)

administered to resident #9 from approximately 1/22/22 through 3/3/22, because it was not available in the home for administration.

Resident #9 is prescribed Sertraline HCL 100 mg-Take 1 tablet by mouth once a day; however, this medication was not administered to resident #9 from approximately 1/22/22 through 3/3/22, because it was not available in the home for administration.

REPEAT VIOLATION: 6/2/2021, et. al.

Plan of Correction

Directed

Immediately a training was scheduled on 5/24/22 for medication management and safety and also diabetes management. All medtechs are required to attend this training. (DIRECTED: Documentation of the education shall be kept. [redacted] 6/1/22).

Moving forward to stay in compliance the resident care coordinator will complete weekly cart audits alternating the 5 carts within the facility verifying all medications are in the home, MAR and match prescribing orders. All residents will be reviewed weekly. (See attached document). (DIRECTED: The weekly audits shall begin within 5 calendar days of receipt of the plan of correction. [redacted] 6/1/22). Families who provide medications were notified via telephone calls from assistant administrator that if medications were not in the facility we would order the prescribed medications from [redacted] pharmacy prior to running out of the medication.

DIRECTED: Within 3 calendar days of receipt of the plan of correction: A designated staff person shall review all of resident #9's medications to ensure all prescribed medications are present in the home and available for administration. [redacted] 6/2/22

[redacted] 10/14/22

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

Not Implemented

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 #8 was admitted to the home on [redacted]; however, no assessment was completed.

REPEAT VIOLATION: 6/2/2021, et. al.

Plan of Correction

Directed

Immediately training was set up with caring hospice to review and re-educate administrator, assistant administrator and resident care coordinators on filling out DME and support plans accurately and timely for 5/31/2022. A complete facility chart audit will be conducted and completed by 5/31/2022 to ensure all support plans are signed by the assessor and is signed by the resident or indicate if the resident is unable to participate, declined to participate or refused/unable to sign. A designated person will complete monthly chart audits.

As of 5/1/2022 all chart started to get audited. All charts have been audited for the month of May.

225a - Assessment 15 Days (continued)

Assistant administrator and a designated med tech will review each chart monthly. The review will ensure that there is a current face sheet, Updated DME that is signed by MD and has licensing number, updated RASP that has proper signature, proper date, proper diet, correct mobility needs.

Management meeting will occur Monday, Wednesday and Friday morning every week and a review will be done on any significant changes. Also, a home health/hospice meeting occurs every Thursday and this will also be reviewed then. Assistant administrator will do all updates.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure an assessment is completed for each newly-admitted resident within 15 days of admission. Copies of the completed new admission checklist shall be kept in each resident's record. 6/2/22.

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

10/14/22
N Implemented

226a - Mobility Assessment

1. Requirements

2600.

226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #1's assessment, dated [redacted] indicates that the resident is moderately immobile; however, the resident is totally immobile and requires the assistance of 2 staff persons to transfer in/out of bed/chair.

Plan of Correction

Directed

Immediately resident #1's mobility assessment was updated on [redacted]. Training was set up with caring hospice to review and re-educate administrator, assistant administrator and resident care coordinators on filling out DME and support plans accurately and timely for 5/31/2022. A complete facility chart audit will be conducted and completed by 5/31/2022 to ensure all mobility needs are reflected accurately. The administrator/assistant administrator will review the initial mobility needs and again after 30 days from admission. A designated person will complete monthly chart audits. As of 5/1/2022 all chart started to get audited. All charts have been audited for the month of May.

Assistant administrator and a designated med tech will review each chart monthly. The review will ensure that there is a current face sheet, Updated DME that is signed by MD and has licensing number, updated RASP that has proper signature, proper date, proper diet, correct mobility needs. (DIRECTED: The monthly chart audit shall begin within 5 calendar days of receipt of the plan of correction. [redacted] 6/1/22).

Management meeting will occur Monday, Wednesday and Friday morning every week and a review will be done on any significant changes. Also, a home health/hospice meeting occurs every Thursday and this will also be reviewed then. Assistant administrator will do all updates. (DIRECTED: Beginning within 72 hours of receipt of the plan of correction: Any changes to resident care needs shall be updated on the resident's assessments and support plans at the conclusion of the weekly meetings. [redacted] 1/22).

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

10/14/22

Document Submission

Implemented

Immediately resident #1's mobility assessment was updated on [redacted]. Training was set up with caring hospice to review and re-educate administrator, assistant administrator and resident care coordinators on filling out DME and support plans accurately and timely for 5/31/2022. A complete facility chart audit will be conducted and

226a - Mobility Assessment (continued)

completed by 5/31/2022 to ensure all mobility needs are reflected accurately. The administrator/assistant administrator will review the initial mobility needs and again after 30 days from admission. A designated person will complete monthly chart audits. As of 5/1/2022 all chart started to get audited. All charts have been audited for the month of May.

Assistant administrator and a designated med tech will review each chart monthly. The review will ensure that there is a current face sheet, Updated DME that is signed by MD and has licensing number, updated RASP that has proper signature, proper date, proper diet, correct mobility needs. (DIRECTED: The monthly chart audit shall begin within 5 calendar days of receipt of the plan of correction. [redacted] 6/1/22).

Management meeting will occur Monday, Wednesday and Friday morning every week and a review will be done on any significant changes. Also, a home health/hospice meeting occurs every Thursday and this will also be reviewed then. Assistant administrator will do all updates. (DIRECTED: Beginning within 72 hours of receipt of the plan of correction: Any changes to resident care needs shall be updated on the resident's assessments and support plans at the conclusion of the weekly meetings. [redacted] 6/1/22).

227g -Support Plan Signatures

1. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #6's most recent support plan, dated [redacted], is not signed by the resident and does not indicate if the resident was unable to participate, declined to participate, refused to sign or is unable to sign.

Resident #7's most recent support plan, dated [redacted] is not signed by the assessor.

Plan of Correction

Directed

Immediately training was set up with caring hospice to review and re-educate administrator, assistant administrator and resident care coordinators on filling out DME and support plans accurately and timely for 5/31/2022. A complete facility chart audit will be conducted and completed by 5/31/2022 to ensure all support plans are signed by the assessor and is signed by the resident or indicate if the resident is unable to participate, declined to participate or refused/unable to sign. A designated person will complete monthly chart audits. (Per discussion with provider on 6/2/22, the monthly chart audits will include an audit of all resident records. [redacted] 6/2/22)

(DIRECTED: The monthly chart audits shall begin within 5 calendar days of receipt of the plan of correction. [redacted] 6/1/22).

Resident #6 is not able to sign the support plan due to not have use of his right side. Resident #6 [redacted] on [redacted] 10/14/22
Resident #7 support plan was signed on 4/15/2022 (see attached document).

Completion Date: 05/31/2022 Licensee's Proposed Date for POC Implementation

Not Implemented