Department of Human Services
Bureau of Human Service Licensing

July 25, 2022

[redacted], COO

RE: BELLE REVE SENIOR LIVING CENTER
404 EAST HARFORD STREET
MILFORD, PA, 18337
LICENSE/COC#: 22513

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/20/2022, 04/21/2022 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: *BELLE REVE SENIOR LIVING CENTER* **License #**: *22513* **License Expiration**: *06/25/2023*

Address: *404 EAST HARFORD STREET, MILFORD, PA 18337*

County: *PIKE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Certificate(s) of Occupancy

Type: *I-1* **Date**: *01/31/2022* **Issued By**: *Milford Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *65* **Waking Staff**: *49*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/21/2022*

Inspection Dates and Department Representative

04/20/2022 - On-Site:
04/21/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served**: *44*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd floor* **Capacity**: *19* **Residents Served**: *14*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *44*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *21* **Have Physical Disability**: *1*

Inspections / Reviews

04/20/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/28/2022*

06/22/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/29/2022*

07/25/2022 - Document Submission

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

65d - Initial Direct Care Training

1. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.

Description of Violation

The home did not have documentation that Staff Person A completed training that included a demonstration of job duties, followed by supervised practice, before Staff Person A began providing unsupervised direct care with residents.

Plan of Correction ***Accept***

2600.65.d.
What: The home did not have documentation that Staff Person A completed training that included a demonstration of job duties, followed by supervised practice, before Staff Person A began providing unsupervised direct care with residents. Memory Care Director and Executive Director had previously observed care with Staff Person A without clear documentation. Executive Director updated New Hire Checklist on 4/29/22 to reflect 4/16/22 observation.
Who: The Executive Director (ED) will train the Management and Business Office Department team on Plan of Correction – Demonstration of Job Duties (Attachment A) and Training Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment C).
When: Training to be completed by 6/17/22.
How: Resident Care Director or designee will supervise a demonstration of job duties for all new direct care staff persons before they provide unsupervised care. This will be documented on the Orientation checklist. Business Office Manager or Designee will assure that Orientation form has documentation of completed training that included demonstration of job duties for all new direct care staff.
Ongoing: The Business Office Director or Designee will conduct a weekly audit of all new hires and the completion of supervised demonstration of job duties and document on Training Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Demonstration of Job Duties
(Attachment A)
Regulation 2600.65(d) - Direct care staff persons hired after April 24, 2006 may not provide unsupervised ADL services until completion of the following:
(1) Training that includes a demonstration of job duties, followed by supervised practice.
(2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
(3) Initial direct care staff person training to include the following:
(i) Safe management techniques.
(ii) ADLs and IADLs.
(iii) Personal hygiene.
(iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
(v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
(vi) Implementation of the initial assessment, annual assessment and support plan. (vii) Nutrition, food handling and sanitation.
(viii) Recreation, socialization, community resources, social services and activities in the community.
(ix) Gerontology.
(x) Staff person supervision, if applicable.

65d - Initial Direct Care Training (continued)

(xi) Care and needs of residents with special emphasis on the residents being served in the home.
(xii) Safety management and hazard prevention.
(xiii) Universal precautions.
(xiv) The requirements of this chapter.
(xv) Infection control.
(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.
Primary Benefit: Ensures that each individual who provides assistance with ADLs is trained to do so properly.
Action Plan: The home did not have documentation that Staff Person A completed training that included a demonstration of job duties, followed by supervised practice, before Staff Person A began providing unsupervised direct care with residents. Memory Care Director and Executive Director had previously observed care with Staff Person A without clear documentation. Executive Director updated New Hire Checklist on 4/29/22 to reflect 4/16/22 observation. The Executive Director (ED) will train the Management and Business Office Department team on Plan of Correction – Demonstration of Job Duties (Attachment A) and Training Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment C). Training to be completed by 6/17/22. Resident Care Director or designee will complete supervised demonstration of job duties for all new direct care staff persons before they provide unsupervised care. This will be documented on the Orientation checklist. Business Office Manager or Designee will assure that Orientation form has documentation of completed training that included demonstration of job duties for all new direct care staff. The Business Office Director or Designee will conduct a weekly audit of all new hires and the completion of supervised demonstration of job duties and document on Training Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

Update: *06/22/2022*

Please send in documentation to support this POC in Step 2 in the Portal.
█, 6-22-22

Document Submission ***Implemented***

2600.65.d.
What: The home did not have documentation that Staff Person A completed training that included a demonstration of job duties, followed by supervised practice, before Staff Person A began providing unsupervised direct care with residents. Memory Care Director and Executive Director had previously observed care with Staff Person A without clear documentation. Executive Director updated New Hire Checklist on 4/29/22 to reflect 4/16/22 observation.
Who: The Executive Director (ED) will train the Management and Business Office Department team on Plan of Correction – Demonstration of Job Duties (Attachment A) and Training Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment C).
When: Training to be completed by 6/17/22.
How: Resident Care Director or designee will supervise a demonstration of job duties for all new direct care staff persons before they provide unsupervised care. This will be documented on the Orientation checklist. Business Office Manager or Designee will assure that Orientation form has documentation of completed training that included demonstration of job duties for all new direct care staff.
Ongoing: The Business Office Director or Designee will conduct a weekly audit of all new hires and the completion of supervised demonstration of job duties and document on Training Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training

65d - Initial Direct Care Training (continued)

Demonstration of Job Duties
(Attachment A)
Regulation 2600.65(d) - Direct care staff persons hired after April 24, 2006 may not provide unsupervised ADL services until completion of the following:
(1) Training that includes a demonstration of job duties, followed by supervised practice.
(2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
(3) Initial direct care staff person training to include the following:
(i) Safe management techniques.
(ii) ADLs and IADLs.
(iii) Personal hygiene.
(iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
(v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
(vi) Implementation of the initial assessment, annual assessment and support plan. (vii) Nutrition, food handling and sanitation.
(viii) Recreation, socialization, community resources, social services and activities in the community.
(ix) Gerontology.
(x) Staff person supervision, if applicable.
(xi) Care and needs of residents with special emphasis on the residents being served in the home.
(xii) Safety management and hazard prevention.
(xiii) Universal precautions.
(xiv) The requirements of this chapter.
(xv) Infection control.
(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.
Primary Benefit: Ensures that each individual who provides assistance with ADLs is trained to do so properly.
Action Plan: The home did not have documentation that Staff Person A completed training that included a demonstration of job duties, followed by supervised practice, before Staff Person A began providing unsupervised direct care with residents. Memory Care Director and Executive Director had previously observed care with Staff Person A without clear documentation. Executive Director updated New Hire Checklist on 4/29/22 to reflect 4/16/22 observation. The Executive Director (ED) will train the Management and Business Office Department team on Plan of Correction – Demonstration of Job Duties (Attachment A) and Training Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment C). Training to be completed by 6/17/22. Resident Care Director or designee will complete supervised demonstration of job duties for all new direct care staff persons before they provide unsupervised care. This will be documented on the Orientation checklist. Business Office Manager or Designee will assure that Orientation form has documentation of completed training that included demonstration of job duties for all new direct care staff. The Business Office Director or Designee will conduct a weekly audit of all new hires and the completion of supervised demonstration of job duties and document on Training Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

82a - Poisonous Materials

1. Requirements

2600.

82a - Poisonous Materials *(continued)*

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

A spray bottle filled with yellow liquid was found located in the home's first floor laundry room. This bottle did not have a manufacturer's label on it to identify the yellow liquid contained in it.

Plan of Correction ***Accept***

2600.82.a
What: A spray bottle filled with yellow liquid was found located in the home's first floor laundry room. This bottle did not have a manufacturer's label on it to identify the yellow contained in it. The spray bottle without an identifying label was immediately removed from the home's laundry room and disposed of on 4/21/22.
Who: The Executive Director (ED) will train the Housekeeping team on Plan of Correction – Poisonous Materials (Attachment D) and Environmental Audit Tool (Attachment E) and complete Sign-in Sheet (Attachment F).
When: Training to be completed by 6/17/22
How: Maintenance Director and housekeepers will assure that all cleaning products considered "poisonous materials" are in original, labeled containers.
Ongoing: Maintenance Director or designee will complete weekly audit of cleaning/poisonous material bottles and document on Environmental Audit Tool (Attachment E). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Poisonous Materials
(Attachment D)
Regulation 2600.82(a) - Poisonous materials shall be stored in their original, labeled containers.
Discussion: "Poisonous materials" include any item labeled "seek medical attention if swallowed" or "contact Poison Control Center if swallowed." These labels occasionally appear on basic personal hygiene items such as toothpaste, mouthwash, deodorant, hand sanitizer, or shampoo; rather than securing these items in a locked area, homes may assess a resident's ability to safely use these items on the resident assessment-support plan, even if the resident cannot safely use other poisonous materials. Cleaning products can be purchased in bulk containers, but spray bottles and stick-on manufacturer's labels provided by the cleaning supply company and manufacturer must be used.
Primary Benefit: Minimizes the possibility that a resident or staff person will mistake a poisonous substance for a harmless substance.
Action Plan: A spray bottle filled with yellow liquid was found located in the home's first floor laundry room. This bottle did not have a manufacturer's label on it to identify the yellow contained in it. The spray bottle without an identifying label was immediately removed from the home's laundry room and disposed of on 4/21/22. The Executive Director (ED) will train the Housekeeping team on Plan of Correction – Poisonous Materials (Attachment D) and Environmental Audit Tool (Attachment E) and complete Sign-in Sheet (Attachment F). Training to be completed by 6/17/22. Maintenance Director and housekeepers will assure that all cleaning products considered "poisonous materials" are in original, labeled containers. Maintenance Director or designee will complete weekly audit of cleaning/poisonous material bottles and document on Environmental Audit Tool (Attachment E). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
█, 6-22-22

82a - Poisonous Materials *(continued)*

Document Submission ***Implemented***

2600.82.a
What: A spray bottle filled with yellow liquid was found located in the home's first floor laundry room. This bottle did not have a manufacturer's label on it to identify the yellow contained in it. The spray bottle without an identifying label was immediately removed from the home's laundry room and disposed of on 4/21/22.
Who: The Executive Director (ED) will train the Housekeeping team on Plan of Correction – Poisonous Materials (Attachment D) and Environmental Audit Tool (Attachment E) and complete Sign-in Sheet (Attachment F).
When: Training to be completed by 6/17/22
How: Maintenance Director and housekeepers will assure that all cleaning products considered "poisonous materials" are in original, labeled containers.
Ongoing: Maintenance Director or designee will complete weekly audit of cleaning/poisonous material bottles and document on Environmental Audit Tool (Attachment E). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Poisonous Materials
(Attachment D)
Regulation 2600.82(a) - Poisonous materials shall be stored in their original, labeled containers.
Discussion: "Poisonous materials" include any item labeled "seek medical attention if swallowed" or "contact Poison Control Center if swallowed." These labels occasionally appear on basic personal hygiene items such as toothpaste, mouthwash, deodorant, hand sanitizer, or shampoo; rather than securing these items in a locked area, homes may assess a resident's ability to safely use these items on the resident assessment-support plan, even if the resident cannot safely use other poisonous materials. Cleaning products can be purchased in bulk containers, but spray bottles and stick-on manufacturer's labels provided by the cleaning supply company and manufacturer must be used.
Primary Benefit: Minimizes the possibility that a resident or staff person will mistake a poisonous substance for a harmless substance.
Action Plan: A spray bottle filled with yellow liquid was found located in the home's first floor laundry room. This bottle did not have a manufacturer's label on it to identify the yellow contained in it. The spray bottle without an identifying label was immediately removed from the home's laundry room and disposed of on 4/21/22. The Executive Director (ED) will train the Housekeeping team on Plan of Correction – Poisonous Materials (Attachment D) and Environmental Audit Tool (Attachment E) and complete Sign-in Sheet (Attachment F). Training to be completed by 6/17/22. Maintenance Director and housekeepers will assure that all cleaning products considered "poisonous materials" are in original, labeled containers. Maintenance Director or designee will complete weekly audit of cleaning/poisonous material bottles and document on Environmental Audit Tool (Attachment E). Findings and trends will be reviewed at the QA meetings.

101j2 - Bedroom Chairs

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

Bedrooms 318 and 324 are both occupied by 2 residents. Bedroom 318 had only one chair, and bedroom 324 had no chairs in the room at time of inspection.

101j2 - Bedroom Chairs *(continued)*

Plan of Correction ***Accept***

2600.101.j.2
What: Bedrooms 318 and 324 are both occupied by 2 residents. Bedroom 318 had only one chair and bedroom 324 had no chairs in the room at time of inspection. This was corrected immediately following survey on 4/21/22. Audit of all rooms completed on 4/24/22 to ensure all rooms have appropriate number of chairs. Any concerns were immediately corrected on 4/25/22.
Who: The Executive Director (ED) will train the Maintenance and Housekeeping teams on Plan of Correction – Bedroom Chairs (Attachment G) and Environmental Audit Tool (Attachment E) and complete Sign-in Sheet (Attachment H).
When: Training to be completed by 6/17/22
How: Maintenance Director and team will assure that all residents have a chair for each resident in resident bedrooms. A wheelchair is satisfactory.
Ongoing: Maintenance Director or designee will complete weekly audit of 5 resident rooms and document on Environmental Audit Tool (Attachment E). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Bedroom Chairs
(Attachment G)
Regulation 2600.101(j)(2) - Each resident shall have the following in the bedroom: A chair for each resident that meets the resident's needs.
Discussion: A resident's wheelchair meets this requirement. A folding chair is permissible if it is sturdy, safe and has been approved by the resident. It is recommended the home document the use of these alternatives in the resident record.
Primary Benefit: A comfortable environment with appropriate furnishings raises the quality of life for residents.
Action Plan: Bedrooms 318 and 324 are both occupied by 2 residents. Bedroom 318 had only one chair and bedroom 324 had no chairs in the room at time of inspection. This was corrected immediately following survey on 4/21/22. Audit of all rooms completed on 4/24/22 to ensure all rooms have appropriate number of chairs. Any concerns were immediately corrected on 4/25/22. The Executive Director (ED) will train the Maintenance and Housekeeping teams on Plan of Correction – Bedroom Chairs (Attachment G) and Environmental Audit Tool (Attachment E) and complete Sign-in Sheet (Attachment H). Training to be completed by 6/17/22 Maintenance Director and team will assure that all residents have a chair for each resident in resident bedrooms. A wheelchair is satisfactory. Maintenance Director or designee will complete weekly audit of 5 resident rooms and document on Environmental Audit Tool (Attachment E). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
AG, 6-22-22

Document Submission ***Implemented***

2600.101.j.2
What: Bedrooms 318 and 324 are both occupied by 2 residents. Bedroom 318 had only one chair and bedroom 324 had no chairs in the room at time of inspection. This was corrected immediately following survey on 4/21/22. Audit of all rooms completed on 4/24/22 to ensure all rooms have appropriate number of chairs. Any concerns were immediately corrected on 4/25/22.

101j2 - Bedroom Chairs (continued)

Who: The Executive Director (ED) will train the Maintenance and Housekeeping teams on Plan of Correction – Bedroom Chairs (Attachment G) and Environmental Audit Tool (Attachment E) and complete Sign-in Sheet (Attachment H).
When: Training to be completed by 6/17/22
How: Maintenance Director and team will assure that all residents have a chair for each resident in resident bedrooms. A wheelchair is satisfactory.
Ongoing: Maintenance Director or designee will complete weekly audit of 5 resident rooms and document on Environmental Audit Tool (Attachment E). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Bedroom Chairs
(Attachment G)
Regulation 2600.101(j)(2) - Each resident shall have the following in the bedroom: A chair for each resident that meets the resident's needs.
Discussion: A resident's wheelchair meets this requirement. A folding chair is permissible if it is sturdy, safe and has been approved by the resident. It is recommended the home document the use of these alternatives in the resident record.
Primary Benefit: A comfortable environment with appropriate furnishings raises the quality of life for residents.
Action Plan: Bedrooms 318 and 324 are both occupied by 2 residents. Bedroom 318 had only one chair and bedroom 324 had no chairs in the room at time of inspection. This was corrected immediately following survey on 4/21/22. Audit of all rooms completed on 4/24/22 to ensure all rooms have appropriate number of chairs. Any concerns were immediately corrected on 4/25/22. The Executive Director (ED) will train the Maintenance and Housekeeping teams on Plan of Correction – Bedroom Chairs (Attachment G) and Environmental Audit Tool (Attachment E) and complete Sign-in Sheet (Attachment H). Training to be completed by 6/17/22 Maintenance Director and team will assure that all residents have a chair for each resident in resident bedrooms. A wheelchair is satisfactory. Maintenance Director or designee will complete weekly audit of 5 resident rooms and document on Environmental Audit Tool (Attachment E). Findings and trends will be reviewed at the QA meetings.

181c - Self-administration Assessment

1. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 is not assessed to self-administers medications, per their assessment and support plan & medical evaluation, both dated 3/11/2022. Resident #1 has been storing an Albuterol Aer HFA emergency inhaler in their bedroom despite not being able to self-administer this medication.

Plan of Correction ***Accept***

2600.181.c.
What: Resident #1 is not assessed to self-administer medications, per their assessment and support plan & medical evaluation, both dated [redacted]. Resident #1 has been storing an [redacted] emergency in their bedroom despite not being able to self-administer this medication. Physician reassessed Resident #1. RASP and DME were updated to reflect that Resident #1 is able to self-administer [redacted] as of 4/21/22.

181c - Self-administration Assessment (continued)

Who: The Resident Care Director (RCD) will train Med Techs and Clinical Leadership Team on Plan of Correction – Self-Administration Assessment (Attachment I) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment K).
When: Training to be completed by 6/17/22.
How: Resident Care Director will assure that all residents who have been assessed to self-administer is reflected on their Resident Support Plan (RASP) and Medical Evaluation (DME). Resident Care Director, Clinical Leadership team, and Med Techs will assure that residents who have not been assessed to self-administer do not have any over the counter (OTC) or prescription medications in their bedroom.
Ongoing: RCD or designee will complete weekly audit and document on Clinical Audit Tool (Attachment J). Weekly audit will review self-admin residents' documentation and audit 5 resident, who do not self-administer, bedrooms for OTC/prescription medications.
Plan of Correction Training
Self-Administration Assessment
(Attachment I)
Regulation 2600.181(c) - A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.
Discussion: Self-explanatory.
Primary Benefit: Ensures that residents who wish to self-administer medications are able to do so safely.
Action Plan: Resident #1 is not assessed to self-administer medications, per their assessment and support plan & medical evaluation, both dated [redacted] Resident #1 has been storing an [redacted] emergency in their bedroom despite not being able to self-administer this medication. Physician reassessed Resident #1. RASP and DME were updated to reflect that Resident #1 is able to self-administer Albuterol as of 4/21/22. The Resident Care Director (RCD) will train Med Techs and Clinical Leadership Team on Plan of Correction – Self-Administration Assessment (Attachment I) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment K). Training to be completed by 6/17/22. Resident Care Director will assure that all residents who have been assessed to self-administer is reflected on their Resident Support Plan (RASP) and Medical Evaluation (DME). Resident Care Director, Clinical Leadership team, and Med Techs will assure that residents who have not been assessed to self-administer do not have any over the counter (OTC) or prescription medications in their bedroom. RCD or designee will complete weekly audit and document on Clinical Audit Tool (Attachment J). Weekly audit will review self-admin residents' documentation and audit 5 resident, who do not self-administer, bedrooms for OTC/prescription medications.

Completion Date: *05/27/2022*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
[redacted], 6-22-22

Document Submission ***Implemented***

2600.181.c.
What: Resident #1 is not assessed to self-administer medications, per their assessment and support plan & medical evaluation, both dated 3/11/2022. Resident #1 has been storing an Albuterol Aer HFA emergency in their bedroom despite not being able to self-administer this medication. Physician reassessed Resident #1. RASP and DME were updated to reflect that Resident #1 is able to self-administer [redacted] as of 4/21/22.

181c - Self-administration Assessment (continued)

Who: The Resident Care Director (RCD) will train Med Techs and Clinical Leadership Team on Plan of Correction – Self-Administration Assessment (Attachment I) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment K).
When: Training to be completed by 6/17/22.
How: Resident Care Director will assure that all residents who have been assessed to self-administer is reflected on their Resident Support Plan (RASP) and Medical Evaluation (DME). Resident Care Director, Clinical Leadership team, and Med Techs will assure that residents who have not been assessed to self-administer do not have any over the counter (OTC) or prescription medications in their bedroom.
Ongoing: RCD or designee will complete weekly audit and document on Clinical Audit Tool (Attachment J). Weekly audit will review self-admin residents' documentation and audit 5 resident, who do not self-administer, bedrooms for OTC/prescription medications.
Plan of Correction Training
Self-Administration Assessment
(Attachment I)
Regulation 2600.181(c) - A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.
Discussion: Self-explanatory.
Primary Benefit: Ensures that residents who wish to self-administer medications are able to do so safely.
Action Plan: Resident #1 is not assessed to self-administer medications, per their assessment and support plan & medical evaluation, both dated [redacted] Resident #1 has been storing an [redacted] emergency in their bedroom despite not being able to self-administer this medication. Physician reassessed Resident #1. RASP and DME were updated to reflect that Resident #1 is able to self-administer [redacted] as of 4/21/22. The Resident Care Director (RCD) will train Med Techs and Clinical Leadership Team on Plan of Correction – Self-Administration Assessment (Attachment I) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment K). Training to be completed by 6/17/22. Resident Care Director will assure that all residents who have been assessed to self-administer is reflected on their Resident Support Plan (RASP) and Medical Evaluation (DME). Resident Care Director, Clinical Leadership team, and Med Techs will assure that residents who have not been assessed to self-administer do not have any over the counter (OTC) or prescription medications in their bedroom. RCD or designee will complete weekly audit and document on Clinical Audit Tool (Attachment J). Weekly audit will review self-admin residents' documentation and audit 5 resident, who do not self-administer, bedrooms for OTC/prescription medications.

183b - Meds and Syringes Locked

1. Requirements

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

Resident #2 is assessed to self-administer their medications with no assistance from others. At time of inspection, Resident #2's medications were stored in their bedroom, in an unlocked bedside table drawer, and in the unlocked medicine cabinet in the resident's bathroom. Resident #2 stated that they do not lock their bedroom door when they leave the room, leaving their medications unlocked and accessible to others.

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

Plan of Correction ***Accept***

183.b.
What: Resident #2 is assessed to self-administer their medication with no assistance from others. At time of inspection, Resident #2's medications were stored in their bedroom, in a unlocked bedside table drawer and in the unlocked medicine cabinet in the resident's bathroom. Resident #2 stated that they do not lock their bedroom door when they leave the room, leaving their medications unlocked and accessible. The immediate solution was for Resident #2 to lock her bedroom door. As of 5/26/22, she will be locking her medications in the locked cabinet in her bedroom.
Who: The Resident Care Director will train Med Techs and Clinical Leadership team on Plan of Correction - Medication Storage (Attachment L) to confirm all prescription medications are appropriately stored in resident rooms, Clinical Audit form (Attachment J) and complete Sign-in Sheet (Attachment M).
When: Training to be completed by 6/17/22.
How: Resident Care Director, Clinical Leadership team, and Med Tech will assure that residents who self-administer medications have them safely stored in a locked container and/or behind a locked door. They will use Clinical Audit form (Attachment J) to ensure medications are stored appropriately in self-administering resident rooms.
Ongoing: Self-administering Resident medication storage will be audited by clinical leadership team using Clinical Audit Form (Attachment J) weekly. Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Meds and Syringes Locked
(Attachment L)
Regulation: 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.
Discussion: Self-explanatory.
Primary Benefit: Medications and syringes will be safe from contamination, spillage or theft and residents who are unable to self-administer medications will be safe from harming themselves with the medications.
Action Plan: Resident #2 is assessed to self-administer their medication with no assistance from others. At time of inspection, Resident #2's medications were stored in their bedroom, in a unlocked bedside table drawer and in the unlocked medicine cabinet in the resident's bathroom. Resident #2 stated that they do not lock their bedroom door when they leave the room, leaving their medications unlocked and accessible. The immediate solution was for Resident #2 to lock ███ bedroom door. As of 5/26/22 ███ will be locking ███ medications in the locked cabinet in ███ bedroom. The Resident Care Director will train Med Techs and Clinical Leadership team on Plan of Correction - Medication Storage (Attachment L) to confirm all prescription medications are appropriately stored in resident rooms, Clinical Audit form (Attachment J) and complete Sign-in Sheet (Attachment M). Training to be completed by 6/17/22. Resident Care Director, Clinical Leadership team, and Med Tech will assure that residents who self-administer medications have them safely stored in a locked container and/or behind a locked door. They will use Clinical Audit form (Attachment J) to ensure medications are stored appropriately in self-administering resident rooms. Self-administering Resident medication storage will be audited by clinical leadership team using Clinical Audit Form (Attachment J) weekly. Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
AG, 6-22-22

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

Document Submission ***Implemented***

183.b.
What: Resident #2 is assessed to self-administer their medication with no assistance from others. At time of inspection, Resident #2's medications were stored in their bedroom, in a unlocked bedside table drawer and in the unlocked medicine cabinet in the resident's bathroom. Resident #2 stated that they do not lock their bedroom door when they leave the room, leaving their medications unlocked and accessible. The immediate solution was for Resident #2 to lock ▇ bedroom door. As of 5/26/22, ▇ will be locking her medications in the locked cabinet in ▇ bedroom.
Who: The Resident Care Director will train Med Techs and Clinical Leadership team on Plan of Correction - Medication Storage (Attachment L) to confirm all prescription medications are appropriately stored in resident rooms, Clinical Audit form (Attachment J) and complete Sign-in Sheet (Attachment M).
When: Training to be completed by 6/17/22.
How: Resident Care Director, Clinical Leadership team, and Med Tech will assure that residents who self-administer medications have them safely stored in a locked container and/or behind a locked door. They will use Clinical Audit form (Attachment J) to ensure medications are stored appropriately in self-administering resident rooms.
Ongoing: Self-administering Resident medication storage will be audited by clinical leadership team using Clinical Audit Form (Attachment J) weekly. Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Meds and Syringes Locked
(Attachment L)
Regulation: 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.
Discussion: Self-explanatory.
Primary Benefit: Medications and syringes will be safe from contamination, spillage or theft and residents who are unable to self-administer medications will be safe from harming themselves with the medications.
Action Plan: Resident #2 is assessed to self-administer their medication with no assistance from others. At time of inspection, Resident #2's medications were stored in their bedroom, in a unlocked bedside table drawer and in the unlocked medicine cabinet in the resident's bathroom. Resident #2 stated that they do not lock their bedroom door when they leave the room, leaving their medications unlocked and accessible. The immediate solution was for Resident #2 to lock her bedroom door. As of 5/26/22 she will be locking her medications in the locked cabinet in ▇ bedroom. The Resident Care Director will train Med Techs and Clinical Leadership team on Plan of Correction - Medication Storage (Attachment L) to confirm all prescription medications are appropriately stored in resident rooms, Clinical Audit form (Attachment J) and complete Sign-in Sheet (Attachment M). Training to be completed by 6/17/22. Resident Care Director, Clinical Leadership team, and Med Tech will assure that residents who self-administer medications have them safely stored in a locked container and/or behind a locked door. They will use Clinical Audit form (Attachment J) to ensure medications are stored appropriately in self-administering resident rooms. Self-administering Resident medication storage will be audited by clinical leadership team using Clinical Audit Form (Attachment J) weekly. Findings and trends will be reviewed at the QA meetings.

183d - Prescription Current

1. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

183d - Prescription Current *(continued)*

Description of Violation

Resident #3 has a medication supply of [redacted], with the order on the label reading "Take 1 tablet by mouth every 4 hours as needed." Resident #3's medication administration record (MAR) does not contain this medication order.

Plan of Correction ***Accept***

2600.183.d.
What: Resident #3 has a medication supply of [redacted], with the order on the label reading "Take 1 tablet by mouth every 4 hours as needed." Resident #3's medication record (MAR) does not contain this medication order. The medication supply of [redacted] without corresponding record in the MAR was sent back to the pharmacy on the evening of 4/21/22.
Who: The Resident Care Director (RCD) will train Med Techs and Clinical Leadership Team on Plan of Correction – Current Prescriptions (Attachment O) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment P).
When: Training to be completed by 6/17/22.
How: Clinical Leadership Team and Med Techs will assure that only current prescriptions are stored in the med cart and kept in the home.
Ongoing: RCD or designee will conduct a weekly cart audit to check that blister cards stored in med carts have a current prescription and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Current Prescriptions
(Attachment L)
Regulation 2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.
Discussion: This regulation requires the disposal of medications that have been discontinued or prescribed for residents who no longer reside in the home. A home may store medications and/or vaccines intended for staff members of the home on the premises of the home. However, medications and/or vaccines which are only intended for staff members of the home should be stored separately from the residents' medications in a locked area that is inaccessible to residents.
Primary Benefit: This regulation requires the disposal of medications that have been discontinued or prescribed for residents who no longer reside in the home. A home may store medications and/or vaccines intended for staff members of the home on the premises of the home. However, medications and/or vaccines which are only intended for staff members of the home should be stored separately from the residents' medications in a locked area that is inaccessible to residents.
Action Plan: Resident #3 has a medication supply of [redacted], with the order on the label reading "Take 1 tablet by mouth every 4 hours as needed." Resident #3's medication record (MAR) does not contain this medication order. The medication supply of [redacted] without corresponding record in the MAR was sent back to the pharmacy on the evening of 4/21/22. The Resident Care Director (RCD) will train Med Techs and Clinical Leadership Team on Plan of Correction – Current Prescriptions (Attachment O) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment P). Training to be completed by 6/17/22. Clinical Leadership Team and Med Techs will assure that only current prescriptions are stored in the med cart and kept in the home. RCD or designee will conduct a weekly cart audit to check that blister cards stored in med carts have a current prescription and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

183d - Prescription Current *(continued)*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
[redacted], 6-22-22

Document Submission ***Implemented***

2600.183.d.
What: Resident #3 has a medication supply of [redacted], with the order on the label reading "Take 1 tablet by mouth every 4 hours as needed." Resident #3's medication record (MAR) does not contain this medication order. The medication supply of [redacted] without corresponding record in the MAR was sent back to the pharmacy on the evening of 4/21/22.
Who: The Resident Care Director (RCD) will train Med Techs and Clinical Leadership Team on Plan of Correction – Current Prescriptions (Attachment O) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment P).
When: Training to be completed by 6/17/22.
How: Clinical Leadership Team and Med Techs will assure that only current prescriptions are stored in the med cart and kept in the home.
Ongoing: RCD or designee will conduct a weekly cart audit to check that blister cards stored in med carts have a current prescription and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Current Prescriptions
(Attachment L)
Regulation 2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.
Discussion: This regulation requires the disposal of medications that have been discontinued or prescribed for residents who no longer reside in the home. A home may store medications and/or vaccines intended for staff members of the home on the premises of the home. However, medications and/or vaccines which are only intended for staff members of the home should be stored separately from the residents' medications in a locked area that is inaccessible to residents.
Primary Benefit: This regulation requires the disposal of medications that have been discontinued or prescribed for residents who no longer reside in the home. A home may store medications and/or vaccines intended for staff members of the home on the premises of the home. However, medications and/or vaccines which are only intended for staff members of the home should be stored separately from the residents' medications in a locked area that is inaccessible to residents.
Action Plan: Resident #3 has a medication supply of [redacted], with the order on the label reading "Take 1 tablet by mouth every 4 hours as needed." Resident #3's medication record (MAR) does not contain this medication order. The medication supply of [redacted] without corresponding record in the MAR was sent back to the pharmacy on the evening of 4/21/22. The Resident Care Director (RCD) will train Med Techs and Clinical Leadership Team on Plan of Correction – Current Prescriptions (Attachment O) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment P). Training to be completed by 6/17/22. Clinical Leadership Team and Med Techs will assure that only current prescriptions are stored in the med cart and kept in the home. RCD or designee will conduct a weekly cart audit to check that blister cards stored in med carts have a current prescription and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

185a - Implement Storage Procedures

1. Requirements

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

Description of Violation

Resident #4's MAR lists 2 PRN orders for [redacted] that read "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4" and "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4." The resident's supply of [redacted] contains a label listing directions for only the former medication directions, and did not contain a label listing the latter medication directions.

Plan of Correction ***Accept***

2600.185.a
What: Resident #4's MAR lists 2 PRN orders for [redacted] that read "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4" and "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4". The resident's supply of [redacted] contain a label listing directions for only the former medication directions and did not contain a label listing the latter medication directions. A new order with the appropriate labels was delivered and started on 5/6/22.
Who: The Resident Care Director will train the Med Techs and Clinical Leadership Team on Plan of Correction – Medication Labels (Attachment Q) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment R).
When: Training to be completed by 6/17/22.
How: The Clinical leadership team will assure that medication labels match the orders noted on the MAR.
Ongoing: The Resident Care Director or designee will conduct a weekly audit to review 3 random MARs in comparison to the corresponding medication labels and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.
Plan of Correction
Medication Labels
(Attachment Q)
Regulation 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.
Discussion: Medical equipment should be regarded in the same manner as medications, as follows:
• Medical equipment should be stored in a safe and secure manner.
• Staff should be properly trained in the use of medical equipment.
• Medical equipment should be maintained and cleaned as per the manufacturer's instructions.
• Medical equipment should be accessible to the resident at all times, and should only be used by the particular resident that it is recommended for.
Primary Benefit: Reduces the risk that medications and medical equipment will be misplaced, lost, or misused.
Action Plan: Resident #4's MAR lists 2 PRN orders for [redacted] that read "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4" and "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4". The resident's supply of [redacted] contain a label listing directions for only the former medication directions and did not contain a label listing the latter medication directions. A new order with the appropriate labels was delivered and started on 5/6/22. The Resident Care Director will train the Med Techs and Clinical Leadership Team on Plan of Correction – Medication Labels (Attachment Q) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment R). Training to be completed by 6/17/22. The Clinical leadership team will assure that medication labels match the orders noted on the MAR. The Resident Care Director

185a - Implement Storage Procedures (continued)

or designee will conduct a weekly audit to review 3 random MARs in comparison to the corresponding medication labels and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
6-22-22

Document Submission ***Implemented***

2600.185.a
What: Resident #4's MAR lists 2 PRN orders for that read "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4" and "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4". The resident's supply of Acetaminophen 325mg contain a label listing directions for only the former medication directions and did not contain a label listing the latter medication directions. A new order with the appropriate labels was delivered and started on 5/6/22.
Who: The Resident Care Director will train the Med Techs and Clinical Leadership Team on Plan of Correction – Medication Labels (Attachment Q) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment R).
When: Training to be completed by 6/17/22.
How: The Clinical leadership team will assure that medication labels match the orders noted on the MAR.
Ongoing: The Resident Care Director or designee will conduct a weekly audit to review 3 random MARs in comparison to the corresponding medication labels and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.
Plan of Correction
Medication Labels
(Attachment Q)
Regulation 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.
Discussion: Medical equipment should be regarded in the same manner as medications, as follows:
• Medical equipment should be stored in a safe and secure manner.
• Staff should be properly trained in the use of medical equipment.
• Medical equipment should be maintained and cleaned as per the manufacturer's instructions.
• Medical equipment should be accessible to the resident at all times, and should only be used by the particular resident that it is recommended for.
Primary Benefit: Reduces the risk that medications and medical equipment will be misplaced, lost, or misused.
Action Plan: Resident #4's MAR lists 2 PRN orders for that read "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4" and "Take 1 tablet by mouth every 6 hours as needed for temperature over 100.4". The resident's supply of contain a label listing directions for only the former medication directions and did not contain a label listing the latter medication directions. A new order with the appropriate labels was delivered and started on 5/6/22. The Resident Care Director will train the Med Techs and Clinical Leadership Team on Plan of Correction – Medication Labels (Attachment Q) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment R). Training to be completed by 6/17/22. The Clinical leadership team will assure that medication labels match the orders noted on the MAR. The Resident Care Director or designee will conduct a weekly audit to review 3 random MARs in comparison to the corresponding medication

185a - Implement Storage Procedures (continued)

labels and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

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 #4 has an order for [redacted] with directions that state "Take 1 tablet by mouth (650mg) every 6 hours as needed for temperature over 100.4." The directions should state that 2 tablets must be administered to total the prescribed dose 650mg.

Plan of Correction ***Accept***

2600.187.a
What: Resident #4 has an order for PRN [redacted] with directions that state "Take 1 tablet by mouth (650mg) every 6 hours as needed for temperature over 100.4." The directions should state that 2 tablets must be administered to total the prescribed does 650mg. A new order with the appropriate labels reflecting the correct number of tablets to dosage was delivered and started on 5/6/22.
Who: The Resident Care Director will train the Med Techs and Clinical Leadership Team on Plan of Correction – Medication Record (Attachment S) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment T).
When: Training to be completed by 6/17/22.
How: The Med Techs and Clinical leadership team will assure that medication orders correctly reflect the appropriate number of tablets and dosage.
Ongoing: The Resident Care Director or designee will conduct a weekly audit to review 3 random prescription orders ensuring it reads the correct number of tablets to corresponding dosage and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

Plan of Correction
Medication Record
(Attachment S)
Regulation 2600.187(a) - A medication record shall be kept including the following for each resident for whom medications are administered:
(1) Resident's name. (2) Drug allergies. (3) Name of medication. (4) Strength. (5) Dosage form. (6) Dose. (7) Route of administration. (8) Frequency of administration. (9) Administration times. (10) Duration of therapy, if applicable. (11) Special precautions, if applicable. (12) Diagnosis or purpose for the medication, including pro re nata (PRN). (13) Date and time of medication administration. (14) Name and initials of the staff person administering the medication.
Discussion: The medication administration record is commonly referred to as the MAR. Proper MAR use is critical, as it:
** Creates a record of proper medication administration*
• Allows physicians and emergency personnel to know when a medication was last administered
• Creates a system to account for medications, especially controlled substances.
Primary Benefit: The home's staff persons will be able to ensure all medications a resident receives and to ensure all medications are administered as prescribed.

187a - Medication Record (continued)

Action Plan: Resident #4 has an order for [redacted] with directions that state "Take 1 tablet by mouth (650mg) every 6 hours as needed for temperature over 100.4." The directions should state that 2 tablets must be administered to total the prescribed does 650mg. A new order with the appropriate labels reflecting the correct number of tablets to dosage was delivered and started on 5/6/22. The Resident Care Director will train the Med Techs and Clinical Leadership Team on Plan of Correction – Medication Record (Attachment S) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment T). Training to be completed by 6/17/22. The Med Techs and Clinical leadership team will assure that medication orders correctly reflect the appropriate number of tablets and dosage. The Resident Care Director or designee will conduct a weekly audit to review 3 random prescription orders ensuring it reads the correct number of tablets to corresponding dosage and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
[redacted], 6-22-22

Document Submission ***Implemented***

2600.187.a
What: Resident #4 has an order for PRN [redacted] with directions that state "Take 1 tablet by mouth (650mg) every 6 hours as needed for temperature over 100.4." The directions should state that 2 tablets must be administered to total the prescribed does 650mg. A new order with the appropriate labels reflecting the correct number of tablets to dosage was delivered and started on 5/6/22.
Who: The Resident Care Director will train the Med Techs and Clinical Leadership Team on Plan of Correction – Medication Record (Attachment S) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment T).
When: Training to be completed by 6/17/22.
How: The Med Techs and Clinical leadership team will assure that medication orders correctly reflect the appropriate number of tablets and dosage.
Ongoing: The Resident Care Director or designee will conduct a weekly audit to review 3 random prescription orders ensuring it reads the correct number of tablets to corresponding dosage and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

Plan of Correction
Medication Record
(Attachment S)
Regulation 2600.187(a) - A medication record shall be kept including the following for each resident for whom medications are administered:
(1) Resident's name. (2) Drug allergies. (3) Name of medication. (4) Strength. (5) Dosage form. (6) Dose. (7) Route of administration. (8) Frequency of administration. (9) Administration times. (10) Duration of therapy, if applicable. (11) Special precautions, if applicable. (12) Diagnosis or purpose for the medication, including pro re nata (PRN). (13) Date and time of medication administration. (14) Name and initials of the staff person administering the medication.
Discussion: The medication administration record is commonly referred to as the MAR. Proper MAR use is critical, as it:
** Creates a record of proper medication administration*

187a - Medication Record (continued)

• Allows physicians and emergency personnel to know when a medication was last administered
• Creates a system to account for medications, especially controlled substances.
Primary Benefit: The home's staff persons will be able to ensure all medications a resident receives and to ensure all medications are administered as prescribed.
Action Plan: Resident #4 has an order for [redacted] with directions that state "Take 1 tablet by mouth (650mg) every 6 hours as needed for temperature over 100.4." The directions should state that 2 tablets must be administered to total the prescribed does 650mg. A new order with the appropriate labels reflecting the correct number of tablets to dosage was delivered and started on 5/6/22. The Resident Care Director will train the Med Techs and Clinical Leadership Team on Plan of Correction – Medication Record (Attachment S) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment T). Training to be completed by 6/17/22. The Med Techs and Clinical leadership team will assure that medication orders correctly reflect the appropriate number of tablets and dosage. The Resident Care Director or designee will conduct a weekly audit to review 3 random prescription orders ensuring it reads the correct number of tablets to corresponding dosage and document on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

190a - Completion Medication Course

1. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Person B currently administers medications to residents. Staff Person B completed the initial Medication Administration training on 8/23/2020 and has not completed the required Annual Practicum since this date, and therefore is not certified to administer medications.

Plan of Correction ***Accept***

2600.190.a.
What: Staff Person B currently administers medications to residents. Staff Person B completed the initial Medication Administration training on 8/23/2020 and has not completed the Annual Practicum since this date, and therefor is not certified to administer medications. Staff Person B to be observed for Annual Practicum upon return from PTO the week of 5/30/2022.
Who: The Executive Director (ED) or designee will train the Med Tech Trainer (current Memory Care Director) and Resident Care Director on Plan of Correction – Med Tech Annual Practicum (Attachment U) and Training Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment V).
When: Training to be completed by 6/17/22.
How: Med Tech Trainer and Resident Care Director will assure that all Med Tech have timely Annual Practicum observation documented.
Ongoing: Med Tech Trainer, RCD or designee will conduct a weekly audit to review who, if any, Med Techs have an Annual Practicum observation due and document that it was completed timely on Training Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Med Tech Annual Practicum
(Attachment L)

190a - Completion Medication Course (continued)

Regulation 2600.190(a) - A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.
Discussion: The Department's approved medications administration course is the Office of Developmental Program's "Train-the-Trainer" course. The course is designed such that once people complete the course offered by the Department, they can train other people to safely administer medications. People who attend the course are taught how to provide initial training and how to complete an "annual practicum".
Trainers (those that took the Trainer-the-Trainer course) are required to monitor the trained (the people who they train) by observing the trained staff administer medications. The number depends on how much time the person has been giving medications and how much time since the person took the original course. The trainer must also review some MARs using a standard rubric. This also depends on which year post initial training a person is in. This constitutes the annual practicum. Trainers that administer medication as well as provide training are required to do the same thing as the students; this can be done by another trainer or by a practicum observer. Trainers are required to take a recertification class every three years.
In order to meet this requirement, as well as § 2600.190(b), a staff member who passed the medication administration course initially must complete the annual practicum as defined by the course every year. The medication administration course/test does not have to be completed every two years.
Primary Benefit: Staff persons will be trained in the proper procedures to safely and correctly administer medications to residents.
Action Plan: Staff Person B currently administers medications to residents. Staff Person B completed the initial Medication Administration training on 8/23/2020 and has not completed the Annual Practicum since this date, and therefor is not certified to administer medications. Staff Person B to be observed for Annual Practicum upon return from PTO the week of 5/30/2022. The Executive Director (ED) will train the Med Tech Trainer (current Memory Care Director) and Resident Care Director on Plan of Correction – Med Tech Annual Practicum (Attachment U) and Training Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment V). Training to be completed by 6/17/22. Med Tech Trainer and Resident Care Director will assure that all Med Tech have timely Annual Practicum observation documented.
Ongoing: Med Tech Trainer, RCD or designee will conduct a weekly audit to review who, if any, Med Techs have an Annual Practicum observation due and document that it was completed timely on Training Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
6-22-22

Document Submission ***Implemented***

2600.190.a.
What: Staff Person B currently administers medications to residents. Staff Person B completed the initial Medication Administration training on 8/23/2020 and has not completed the Annual Practicum since this date, and therefor is not certified to administer medications. Staff Person B to be observed for Annual Practicum upon return from PTO the week of 5/30/2022.
Who: The Executive Director (ED) or designee will train the Med Tech Trainer (current Memory Care Director) and

190a - Completion Medication Course (continued)

Resident Care Director on Plan of Correction – Med Tech Annual Practicum (Attachment U) and Training Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment V).
When: Training to be completed by 6/17/22.
How: Med Tech Trainer and Resident Care Director will assure that all Med Tech have timely Annual Practicum observation documented.
Ongoing: Med Tech Trainer, RCD or designee will conduct a weekly audit to review who, if any, Med Techs have an Annual Practicum observation due and document that it was completed timely on Training Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Med Tech Annual Practicum
(Attachment L)
Regulation 2600.190(a) - A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.
Discussion: The Department's approved medications administration course is the Office of Developmental Program's "Train-the-Trainer" course. The course is designed such that once people complete the course offered by the Department, they can train other people to safely administer medications. People who attend the course are taught how to provide initial training and how to complete an "annual practicum".
Trainers (those that took the Trainer-the-Trainer course) are required to monitor the trained (the people who they train) by observing the trained staff administer medications. The number depends on how much time the person has been giving medications and how much time since the person took the original course. The trainer must also review some MARs using a standard rubric. This also depends on which year post initial training a person is in. This constitutes the annual practicum. Trainers that administer medication as well as provide training are required to do the same thing as the students; this can be done by another trainer or by a practicum observer. Trainers are required to take a recertification class every three years.
In order to meet this requirement, as well as § 2600.190(b), a staff member who passed the medication administration course initially must complete the annual practicum as defined by the course every year. The medication administration course/test does not have to be completed every two years.
Primary Benefit: Staff persons will be trained in the proper procedures to safely and correctly administer medications to residents.
Action Plan: Staff Person B currently administers medications to residents. Staff Person B completed the initial Medication Administration training on 8/23/2020 and has not completed the Annual Practicum since this date, and therefor is not certified to administer medications. Staff Person B to be observed for Annual Practicum upon return from PTO the week of 5/30/2022. The Executive Director (ED) will train the Med Tech Trainer (current Memory Care Director) and Resident Care Director on Plan of Correction – Med Tech Annual Practicum (Attachment U) and Training Audit Tool (Attachment B) and complete Sign-in Sheet (Attachment V). Training to be completed by 6/17/22. Med Tech Trainer and Resident Care Director will assure that all Med Tech have timely Annual Practicum observation documented.
Ongoing: Med Tech Trainer, RCD or designee will conduct a weekly audit to review who, if any, Med Techs have an Annual Practicum observation due and document that it was completed timely on Training Audit Tool (Attachment B). Findings and trends will be reviewed at the QA meetings.

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 #5's assessment and support plan (RASP) dated [redacted] was not signed by the resident, and there is no documentation to indicate that the resident refused to or was unable to sign their RASP.

Plan of Correction ***Accept***

2600.227.g.
What: Resident #5's assessment and support plan (RASP) dated [redacted] was not signed by the resident, and there was no documentation to indicate that the resident refused to or was unable to sign. Resident #5's RASP signature page was updated on [redacted] to indicate that Resident #5 was unable to sign.
Who: The Executive Director (ED) will train Resident Care Director and Memory Care Director on Plan of Correction – Support Plan Signatures (Attachment W) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment X).
When: Training to be completed by 6/17/22.
How: Resident Care Director and Memory Care Director will assure that all participants in RASP review have signed or otherwise indicated.
Ongoing: RCD, MCD, or designee will conduct a weekly audit to review RASPs due and appropriate signature documentation on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Support Plan Signatures
(Attachment W)
Regulation 2600.227(g) - Individuals who participate in the development of the support plan shall sign and date the support plan.
Discussion: All staff persons (including contractors of the home) who participate in the development of the plan must sign the plan.
Primary Benefit: Having individuals who participate in the development of the support plan sign and date the support plan provides a record of who participated in the development of the support plan for future reference purposes.
Action Plan: Resident #5's assessment and support plan (RASP) dated [redacted] was not signed by the resident, and there was no documentation to indicate that the resident refused to or was unable to sign. Resident #5's RASP signature page was updated on [redacted] to indicate that Resident #5 was unable to sign. The Executive Director (ED) will train Resident Care Director and Memory Care Director on Plan of Correction – Support Plan Signatures (Attachment W) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment X). Training to be completed by 6/17/22. Resident Care Director and Memory Care Director will assure that all participants in RASP review have signed or otherwise indicated. RCD, MCD, or designee will conduct a weekly audit to review RASPs due and appropriate signature documentation on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
Please send in a copy of a recently signed support plan as well to show compliance.
[redacted], 6-22-22

227g -Support Plan Signatures *(continued)*

Document Submission ***Implemented***

2600.227.g.
What: Resident #5's assessment and support plan (RASP) dated 1/20/22 was not signed by the resident, and there was no documentation to indicate that the resident refused to or was unable to sign. Resident #5's RASP signature page was updated on 4/25/22 to indicate that Resident #5 was unable to sign.
Who: The Executive Director (ED) will train Resident Care Director and Memory Care Director on Plan of Correction – Support Plan Signatures (Attachment W) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment X).
When: Training to be completed by 6/17/22.
How: Resident Care Director and Memory Care Director will assure that all participants in RASP review have signed or otherwise indicated.
Ongoing: RCD, MCD, or designee will conduct a weekly audit to review RASPs due and appropriate signature documentation on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Support Plan Signatures
(Attachment W)
Regulation 2600.227(g) - Individuals who participate in the development of the support plan shall sign and date the support plan.
Discussion: All staff persons (including contractors of the home) who participate in the development of the plan must sign the plan.
Primary Benefit: Having individuals who participate in the development of the support plan sign and date the support plan provides a record of who participated in the development of the support plan for future reference purposes.
Action Plan: Resident #5's assessment and support plan (RASP) dated [redacted] was not signed by the resident, and there was no documentation to indicate that the resident refused to or was unable to sign. Resident #5's RASP signature page was updated on 4/25/22 to indicate that Resident #5 was unable to sign. The Executive Director (ED) will train Resident Care Director and Memory Care Director on Plan of Correction – Support Plan Signatures (Attachment W) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment X). Training to be completed by 6/17/22. Resident Care Director and Memory Care Director will assure that all participants in RASP review have signed or otherwise indicated. RCD, MCD, or designee will conduct a weekly audit to review RASPs due and appropriate signature documentation on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

234d - Support Plan Revision

1. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #5 currently utilizes an enabler bar. Resident #5's assessment and support plan (RASP) dated [redacted] does not include the resident's need for use of an enabler bar to assist with transfers.

Resident #6 is currently prescribed a mechanical soft diet. Resident #6's RASP dated 3/31/22 does not include the resident's special dietary needs and the home's plan to meet these needs.

234d - Support Plan Revision *(continued)*

Plan of Correction ***Accept***

2600.234.d.
What: Resident #5 currently utilizes and enabler bar. Resident #5's assessment and support plan (RASP) dated [redacted] does not include the resident's need for use of an enabler bar to assist with transfers. Resident #5's RASP was updated on 4/25/22 to reflect use of enabler bar for transfers in and out of bed.
Resident #6 is currently prescribed a mechanical soft diet. Resident #6's RASP dated [redacted] does not include the resident's special dietary needs and the home's plan to meet these needs. Resident #6 RASP has been updated to reflect dietary needs. Since time of inspection, Resident #6 was downgraded to a [redacted] on [redacted] RASP has been updated to reflect this change.
Who: The Executive Director (ED) will train Resident Care Director and Memory Care Director on Plan of Correction – Support Plan Revision (Attachment Y) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment Z).
When: Training to be completed by 6/17/22.
How: Resident Care Director and Memory Care Director will assure that all RASPs reflect resident use of assistive devices, like enabler bars, and resident diet restrictions or dietary needs.
Ongoing: RCD, MCD, or designee will conduct a weekly audit to review RASPs due and appropriate assistive device and diet related documentation on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Support Plan Review
(Attachment Y)
Regulation 2600.234(d) - The support plan shall be revised at least annually and as the resident's condition changes.
Discussion: Please see "The Preadmission Screening, Medical Evaluation, and Assessment-Support Plan: Best Practices" in "Regulatory Issues and Frequently-Occurring Situations" for more information.
Primary Benefit: A person with dementia has rapidly changing mental health and physical health needs; a current assessment-support plan can help to specify how the home will meet the needs of the resident identified in the assessment. It is critical that the home immediately revise the support plan after a significant change to address life safety issues and/or changing needs.
Action Plan: Resident #5 currently utilizes and enabler bar. Resident #5's assessment and support plan (RASP) dated [redacted] does not include the resident's need for use of an enabler bar to assist with transfers. Resident #5's RASP was updated on [redacted] to reflect use of enabler bar for transfers in and out of bed. Resident #6 is currently prescribed a mechanical soft diet. Resident #6's RASP dated [redacted] does not include the resident's special dietary needs and the home's plan to meet these needs. Resident #6 RASP has been updated to reflect dietary needs. Since time of inspection, Resident #6 was downgraded to a [redacted] on [redacted]. RASP has been updated to reflect this change. The Executive Director (ED) will train Resident Care Director and Memory Care Director on Plan of Correction – Support Plan Revision (Attachment Y) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment Z). Training to be completed by 6/17/22. Resident Care Director and Memory Care Director will assure that all RASPs reflect resident use of assistive devices, like enabler bars, and resident diet restrictions or dietary needs. RCD, MCD, or designee will conduct a weekly audit to review RASPs due and appropriate assistive device and diet related documentation on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.

Completion Date: *05/27/2022*

234d - Support Plan Revision *(continued)*

Update: *06/22/2022*

All attachments to support the POC have to be sent via the Portal in Step 2. Please don't send in any BLANK audit sheets. Send in sheets that are actually in use to demonstrate compliance.
[redacted], 6-22-22

Document Submission ***Implemented***

2600.234.d.
What: Resident #5 currently utilizes and enabler bar. Resident #5's assessment and support plan (RASP) dated [redacted] does not include the resident's need for use of an enabler bar to assist with transfers. Resident #5's RASP was updated on [redacted] to reflect use of enabler bar for transfers in and out of bed.
Resident #6 is currently prescribed a mechanical soft diet. Resident #6's RASP dated [redacted] does not include the resident's special dietary needs and the home's plan to meet these needs. Resident #6 RASP has been updated to reflect dietary needs. Since time of inspection, Resident #6 was downgraded to a [redacted] on [redacted]. RASP has been updated to reflect this change.
Who: The Executive Director (ED) will train Resident Care Director and Memory Care Director on Plan of Correction – Support Plan Revision (Attachment Y) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment Z).
When: Training to be completed by 6/17/22.
How: Resident Care Director and Memory Care Director will assure that all RASPs reflect resident use of assistive devices, like enabler bars, and resident diet restrictions or dietary needs.
Ongoing: RCD, MCD, or designee will conduct a weekly audit to review RASPs due and appropriate assistive device and diet related documentation on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.
Plan of Correction Training
Support Plan Review
(Attachment Y)
Regulation 2600.234(d) - The support plan shall be revised at least annually and as the resident's condition changes.
Discussion: Please see "The Preadmission Screening, Medical Evaluation, and Assessment-Support Plan: Best Practices" in "Regulatory Issues and Frequently-Occurring Situations" for more information.
Primary Benefit: A person with dementia has rapidly changing mental health and physical health needs; a current assessment-support plan can help to specify how the home will meet the needs of the resident identified in the assessment. It is critical that the home immediately revise the support plan after a significant change to address life safety issues and/or changing needs.

234d - Support Plan Revision (continued)

Action Plan: Resident #5 currently utilizes and enabler bar. Resident #5's assessment and support plan (RASP) dated [redacted] does not include the resident's need for use of an enabler bar to assist with transfers. Resident #5's RASP was updated on [redacted] to reflect use of enabler bar for transfers in and out of bed. Resident #6 is currently prescribed a mechanical soft diet. Resident #6's RASP dated [redacted] does not include the resident's special dietary needs and the home's plan to meet these needs. Resident #6 RASP has been updated to reflect dietary needs. Since time of inspection, Resident #6 was downgraded to a [redacted] on [redacted]. RASP has been updated to reflect this change. The Executive Director (ED) will train Resident Care Director and Memory Care Director on Plan of Correction – Support Plan Revision (Attachment Y) and Clinical Audit Tool (Attachment J) and complete Sign-in Sheet (Attachment Z). Training to be completed by 6/17/22. Resident Care Director and Memory Care Director will assure that all RASPs reflect resident use of assistive devices, like enabler bars, and resident diet restrictions or dietary needs. RCD, MCD, or designee will conduct a weekly audit to review RASPs due and appropriate assistive device and diet related documentation on Clinical Audit Tool (Attachment J). Findings and trends will be reviewed at the QA meetings.