

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

**Facility Information**

Name: *HARMONY AT HARTS RUN* License #: *45322* License Expiration: *11/15/2022*  
Address: *3450 HARTS RUN ROAD, GLENSHAW, PA 15116*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *FOX CHAPEL OPERATIONS LLC*  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-1* Date: *05/08/2021* Issued By: *Township of Indiana*  
Type: *I-2* Date: *08/23/2021* Issued By: *Township of Indiana*

**Staffing Hours**

Resident Support Staff: *2* Total Daily Staff: *65* Waking Staff: *49*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Complaint* Exit Conference Date: *07/08/2022*

**Inspection Dates and Department Representative**

06/21/2022 - On-Site: [REDACTED]  
06/22/2022 - On-Site: [REDACTED]  
06/23/2022 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *114* Residents Served: *48*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Harmony Square, 1st floor* Capacity: *40* Residents Served: *11*

**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *48*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *15* Have Physical Disability: *1*

## Inspections / Reviews

06/21/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/23/2022*

07/25/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/29/2022*

08/02/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *08/31/2022*

09/02/2022 - Document Submission

Reviewer: [REDACTED] Follow-Up Type: *Exception* Follow-Up Date:

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

On the mornings of 6/21/22 and 6/22/22, staff person A's record was requested by an agent of the Department; however, staff person A's record was not provided until 6/22/22 at 1:10 p.m.

Plan of Correction

Accept

A second member of the management team will be present during all conversations related to requests for records with any Agent of the Department to document requests and assist in providing requested records in order to meet the requirements of this regulation. All staff persons involved in providing access to the home, the residents and records to Agents of the Department will be educated on this plan of correction and responsibilities by 08/05/22. Documentation of the education shall be kept. All staff and resident records will be reviewed to ensure they are all present in the home and would be available to the department immediately upon request by 8/5/22.

Completion Date: 08/05/2022 Licensee's Proposed Date for POC Implementation

9/2/22

Document Submission

emented

A second member of the management team will be present during all conversations related to requests for records with any Agent of the Department to document requests and assist in providing requested records in order to meet the requirements of this regulation. All staff persons involved in providing access to the home, the residents and records to Agents of the Department will be educated on this plan of correction and responsibilities by 08/05/22. Documentation of the education shall be kept. All staff and resident records will be reviewed to ensure they are all present in the home and would be available to the department immediately upon request by 8/5/22.

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

Resident #1 resides in the home's secured dementia care unit (SDCU). On 6/4/22 at approximately 7:00 p.m., resident #1 had an unwitnessed fall in the resident's room and resident #1 crawled out of bedroom to the nurse's station. Resident #1 was sent to the hospital on 6/6/22 and was admitted with a left eye occipital condyle fracture and a right knee fracture. However, this incident was not reported to the Department until 6/9/22.

Plan of Correction

Accept

Internal incident report forms will be used to document a resident incident and the medtech or Nurse in charge each shift will be responsible to contact the Healthcare Director, Executive Director or Designee to inform them of any resident incidents. The Healthcare Director, Executive Director or Designee will be responsible to report the incident to the department within 24 hours. All staff will be educated on this plan of correction and responsibilities by 08/10/22. Documentation of the education shall be kept. Results will be reviewed at the monthly Quality Management Meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation.

Completion Date: 08/10/2022 Licensee's Proposed Date for POC Implementation

16c - Written Incident Report (continued)

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██████████ ented

**Document Submission**

Internal incident report forms will be used to document a resident incident and the medtech or Nurse in charge each shift will be responsible to contact the Healthcare Director, Executive Director or Designee to inform them of any resident incidents. The Healthcare Director, Executive Director or Designee will be responsible to report the incident to the department within 24 hours. All staff will be educated on this plan of correction and responsibilities by 08/10/22. Documentation of the education shall be kept. Results will be reviewed at the monthly Quality Management Meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation.

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

**Description of Violation**

On 6/21/22, numerous resident records and resident information were unlocked, unattended and accessible at multiple nurse's stations to include the following:

At 9:20 a.m., at the SDCU nurses station:

- Shower schedule with room numbers, to include residents in bedrooms ██████████
- Resident #1's hospice record
- Resident #2's weight and vital sign record
- Medication lists for residents #3 and #4
- 10 Resident records on a shelf in the unlocked medication room, to include resident #1's record

At 9:44 a.m., at the 2nd floor nurse's station:

- Resident #5's face sheet, which includes resident #5's date of birth, medical diagnoses, insurance information and resident #5's after visit summary, dated 5/31/22
- Resident #6's physician orders, dated 6/13/22
- Resident #7's resident record

At approximately 10:00 a.m., at the 3rd floor nurse's station:

- Resident #6's pharmacy order for Gabapentin-100mg capsules
- Resident #8's pharmacy order for Alprazolam-0.5mg tablets
- Resident #9's pharmacy order for Lyrica-75mg capsules

**Plan of Correction**

**Directed**

Audits of the nursing stations will be conducted weekly by the Healthcare Director or Designated Person to ensure all resident records and information are stored in a manner that maintains confidentiality in accordance with this regulation. All staff will be educated on this plan of correction and responsibilities by 08/10/22. Documentation of the education shall be kept. Results of weekly audits will be reviewed at the monthly Quality Management Meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation. A designated person shall inspect the home daily for one month then weekly thereafter to ensure all resident information is kept in an area that is locked. Documentation of the audits shall be kept. (DIRECTED: The daily audits shall begin within 48 hours of receipt of the plan of correction. ██████████ 8/2/22).

Completion Date: 08/10/2022 Licensee's Proposed Date for POC Implementation

██████████ 9/2/22  
**Not Implemented**

23a - Activities of Daily Living Assistance

1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident’s assessment and support plan.

Description of Violation

Resident #10’s assessment and support plan, dated [redacted] indicates resident #10 requires total physical assistance with toileting and personal hygiene, requires some physical assistance with ambulating and is totally immobile. However, according to the home’s call bell report, resident #10 waited an excessive amount of time for staff assistance on numerous occasions, to include the following dates/times:

- 59 minutes on 6/15/22 at 7:26 p.m.
- Over 84 minutes on 6/16/22 at 2:43 a.m.
- Over 84 minutes on 6/16/22 at 12:32 p.m.
- Over 78 minutes on 6/17/22 at 8:20 p.m.

Plan of Correction

Directed

Call bell reports will be reviewed three days a week by the Executive Director, Healthcare Director or Designee to ensure staff assistance is provided in a manner consistent with the needs of residents in their assessment and support plan. All staff will be educated on this plan of correction and responsibilities by 08/10/22. All staff will be educated on using walkie talkies to communicate regarding call bells and the importance of resetting pull cords and pendants as soon as they have arrived to assist a resident, both of which are root causes to this violation. Documentation of the education shall be kept. Results of weekly audits will be reviewed at the monthly Quality Management Meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation. A designated staff person shall also interview 5 residents who require assistance per month to ensure residents receive timely assistance through December 2022. (DIRECTED: The resident interviews shall begin within 72 hours of receipt of the plan of correction. Documentation of the interviews shall be kept [redacted] 8/2/22). Results will be discussed at the monthly Quality Management meeting [redacted] 9/2/22

Completion Date: 08/12/2022 Licensee’s Proposed Date for POC Implementation

Not Implemented

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident’s designated person if any, if the resident agrees.

Description of Violation

Resident #1’s resident-home contract, dated 4/21/22, is not signed by the resident.

Resident #3’s resident-home contract, dated 4/21/22, is not signed by the resident. Also, resident #3’s resident-home contract was not signed by the administrator and resident #3’s designated person until 5/2/22.

Resident #6’s resident-home contract, dated 5/27/22, is not signed by the resident.

Plan of Correction

Directed

Resident # 1’s contract is not signed by the resident since [redacted] is on hospice with deteriorating health, Resident # 3’s contract is not signed by the resident as [redacted] is unable to make a mark as signature, Resident #6’s contract is not signed by the resident as [redacted] is unable to see to sign due to macular degeneration. All three contracts will be

25b - Contract Signatures (continued)

noted with "unable to sign" by 8/5/2022. Resident-home contracts will be signed by all appropriate parties the day prior to admission or upon arrival by the resident to the community on day of admission. The contract will be reviewed by the Business Office Manager no later than day of admission to ensure required signatures were obtained. Audits of new resident contracts will be conducted monthly by the Executive Director, Business Office Manager or Designated Person and results will be reviewed at the monthly Quality Management Meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation. The Executive Director, BOM or Designee will be responsible to review resident contracts for signatures of all parties by 7/31/22. The Resident Administrative checklist will be used and signed for audit of this regulation the day of Admission by the Executive Director, Business Office Manager or Designee and will begin 08/01/22. All staff persons involved in the admission process will be educated on this plan of correction and responsibilities by 08/10/22. Documentation of the education shall be kept. (DIRECTED: Copies of the completed new admission checklist shall be kept in each resident's record. [redacted] 8/2/22).

Completion Date: 08/05/2022 Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] 9/2/22

41e - Signed Statement

1. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Residents #3 and #6's resident records do not include a statement signed by the residents acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction

Accept

Resident # 3's contract is not signed by the resident as [redacted] is unable to make a mark as signature, Resident #6's contract is not signed by the resident as [redacted] is unable to see to sign due to macular degeneration. Both contracts will be noted with "unable to sign" by 8/5/2022. Resident-home contracts will be signed by all appropriate parties the day prior to admission or upon arrival by the resident to the community on day of admission. The contract will be reviewed by the Business Office Manager no later than day of admission to ensure required signatures were obtained. Audits of new resident contracts will be conducted monthly by the Executive Director, Business Office Manager or Designated Person and results will be reviewed at the monthly Quality Management Meeting x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation. The Executive Director, BOM or Designee will be responsible to review resident contracts for signatures of all parties by 7/31/22. The Resident Administrative checklist will be used and signed for audit of this regulation the day of Admission by the Executive Director, Business Office Manager or Designee and will begin 08/01/22. All staff persons involved in the admission process will be educated on this plan of correction and responsibilities by 08/10/22. Documentation of the education shall be kept. Copies of the completed new admission checklists shall be kept in each resident's record.

Completion Date: 08/05/2022 Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] 9/2/22

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

Resident #1 resides in the home's SDCU. On 6/4/22 at approximately 7:00 p.m., resident #1 had an unwitnessed fall in [redacted] bedroom and resident #1 crawled out of [redacted] bedroom to the nurse's station. Staff members indicated resident #1 sustained a laceration and bruise to the right eye, bruise on [redacted] chin, open skin tear to the right arm and complained of knee pain. Resident #1 was assisted back to bed. However, resident #1 was not sent to the hospital for evaluation/treatment until 6/6/22 at 3:15 a.m., where resident #1 was admitted for numerous injuries related to the fall, to include a left occipital condyle fracture and a right knee fracture.

Plan of Correction

Accept

All residents will be assessed by a medtech or nurse on duty post incident for injuries and the need for treatment at a hospital. The medtech or nurse on duty will complete an incident report form and notify the Healthcare Director, Executive Director or Designee of the incident. All staff persons will be educated on Abuse under this regulation and the responsibilities of this plan of correction by 08/10/22. Medtechs and Nurses will be re-educated by the Healthcare Director or Designee as to the requirements related to assessing residents both post-fall and post-injury by 8/15/22. Documentation of the education shall be kept. Assessments will be reviewed as part of the Resident Incident Form review by the Healthcare Director or Executive Director to ensure their completion. This will also be reviewed with staff during an All Staff Meeting on a quarterly basis and audited for completion at a monthly Quality Management Meeting by 8/31/22 and quarterly thereafter.

Completion Date: 08/15/2022 Licensee's Proposed Date for POC Implementation

Not Implemented

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person B, hired on [redacted] did not receive orientation on any of the topics specified in 2600.65a until 6/29/22.

Direct care staff person C, hired on [redacted] did not receive orientation on any of the topics specified in 2600.65a until 6/29/22.

Plan of Correction

Directed

All new hires will have orientation in general fire safety and emergency preparedness at the start of orientation on day one of employment. It will be the responsibility of the Business Office Manager to arrange this training, ensure

65a - FS Orientation 1st Day (continued)

it is completed and documented on the orientation checklist. The BOM will sign the orientation checklist indicating completion of all required orientation under this regulation and it will be retained in each staff persons record. (DIRECTED: The staff person receiving the orientation shall also sign the training documents. [redacted] 8/2/22). All new hire orientation checklists will be audited by the Executive Director or Designee weekly x 8 weeks for compliance to this regulation. (DIRECTED: The weekly audits shall begin within 72 hours of receipt of the plan of correction. [redacted] 8/2/22). Audit period will be extended at that time if further episodes of non-compliance are observed in the final audit. All persons involved with the hiring and orientation process will be educated on this plan of correction and responsibilities by 8/10/22 and will be placed in each employee record. Documentation of the education shall be kept.

DIRECTED: Within 7 calendar days of receipt of the plan of correction: A designated staff person shall review all current staff person records to ensure each staff person has received training on all topics indicated in 2600.65a. Documentation of training shall be kept in each staff person's record. [redacted] 8/2/22 [redacted] 9/2/22  
Completion Date: 08/05/2022 Licensee's Proposed Date for POC Implementation **Not Implemented**

82a - Poisonous Materials

1. Requirements

2600.  
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 6/21/22 at 9:20 a.m., there were 2 unlabeled spray bottles containing a clear liquid in the unlocked SDCU medication room.

Plan of Correction

Accept

The poisonous materials were removed at time of inspection. All staff will be educated on poisonous materials requirements under this regulation by 8/10/22. Documentation of the education shall be kept. The Healthcare Director or Designee will be responsible to check nursing stations on each shift to ensure that no unlabeled bottles are present and remove them from the community. These checks will be documented and retained. Audits to ensure compliance of this plan of correction will occur twice a week x 8 weeks. Audit period will be extended at that time if further episodes of non-compliance are observed in the final audit. This will also be reviewed with staff during an All Staff Meeting on a quarterly basis and audited for completion at the monthly Quality Management Meeting by 8/31/22 x 3.

Completion Date: 08/10/2022 Licensee's Proposed Date for POC Implementation

[redacted] 9/2/22

Document Submission

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The poisonous materials were removed at time of inspection. All staff will be educated on poisonous materials requirements under this regulation by 8/10/22. Documentation of the education shall be kept. The Healthcare Director or Designee will be responsible to check nursing stations on each shift to ensure that no unlabeled bottles are present and remove them from the community. These checks will be documented and retained. Audits to ensure compliance of this plan of correction will occur twice a week x 8 weeks. Audit period will be extended at that time if further episodes of non-compliance are observed in the final audit. This will also be reviewed with staff during an All Staff Meeting on a quarterly basis and audited for completion at the monthly Quality Management Meeting by 8/31/22 x 3.

82c - Locking Poisonous Materials

1. Requirements

2600.

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

Description of Violation

On 6/21/22 at 9:20 a.m., numerous poisonous materials with manufacturers' labels indicating, "If swallowed get medical help or contact poison control center", were unlocked, unattended and accessible in the SDCU nurse's station medication room, to include the following:

- A 32-ounce bottle of Windex, approximately ¾ full
- A 32-ounce bottle of Reliable liquid cream cleaner, approximately ¾ full
- A 32-ounce bottle of Reliable liquid cream cleaner, which was full

The current residents who reside in the SDCU are not assessed as capable of recognizing and using poisons safely.

On 6/21/22 at 9:55 a.m., there were (2) 2.95-liter bottles of Giant Eagle Ultra Free & Clear detergent with manufacturers' labels indicating, "If swallowed get medical help or contact poison control center", unlocked, unattended and accessible in the 2nd floor laundry room. Resident #6 resides on the 2nd floor and has not been assessed as capable of recognizing and using poisons safely.

Plan of Correction

Accept

All of the poisonous materials were removed at time of inspection. All staff will be educated on poisonous materials requirements under this regulation by 8/10/22. Documentation of the education shall be kept. The Healthcare Director or Designee will be responsible to check nursing stations and laundry rooms on each shift to ensure no poisonous materials are present and if found, will be stored where they are locked and inaccessible to residents. Laundry rooms will also be checked 3 times daily to ensure the laundry room is locked and inaccessible to residents. These checks will be documented and retained. Audits to ensure compliance of this plan of correction will occur twice a week x 8 weeks. Audit period will be extended at that time if further episodes of non-compliance are observed in the final audit. This will also be reviewed with staff during an All Staff Meeting on a quarterly basis and audited for completion at a monthly Quality Management Meeting to start by 8/31/22 x 3.

Completion Date: 08/10/2022 Licensee's Proposed Date for POC Implementation

9/2/22  
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Document Submission

All of the poisonous materials were removed at time of inspection. All staff will be educated on poisonous materials requirements under this regulation by 8/10/22. Documentation of the education shall be kept. The Healthcare Director or Designee will be responsible to check nursing stations and laundry rooms on each shift to ensure no poisonous materials are present and if found, will be stored where they are locked and inaccessible to residents. Laundry rooms will also be checked 3 times daily to ensure the laundry room is locked and inaccessible to residents. These checks will be documented and retained. Audits to ensure compliance of this plan of correction will occur twice a week x 8 weeks. Audit period will be extended at that time if further episodes of non-compliance are observed in the final audit. This will also be reviewed with staff during an All Staff Meeting on a quarterly basis and audited for completion at a monthly Quality Management Meeting to start by 8/31/22 x 3.

142a - Secure Medical Care

1. Requirements

2600.

142a - Secure Medical Care (continued)

142.a. The home shall assist the resident to secure medical care if a resident’s health status declines. The home shall document the resident’s need for the medical care, including updating the resident’s assessment and support plan.

Description of Violation

Resident #1 resides in the home’s SDCU. On 6/4/22 at approximately 7:00 p.m., resident #1 had an unwitnessed fall in [redacted] bedroom and resident #1 crawled out of [redacted] bedroom to the nurse’s station. Staff members indicated resident #1 sustained a laceration and bruise to the right eye, bruise on [redacted] chin, open skin tear to the right arm and complained of knee pain. Resident #1 was assisted back to bed. However, resident #1 was not sent to the hospital for evaluation/treatment until 6/6/22 at 3:15 a.m., where resident #1 was admitted for numerous injuries related to the fall, to include a left occipital condyle fracture and a right knee fracture. Upon return from the hospital on 6/10/22, the home did not complete an assessment and support plan for resident #1 to meet medical care needs, to include a right knee immobilizer, soft neck collar from the fall or the admission to hospice care, which occurred on 6/10/22.

Some time during the night of 5/29/22, resident #6 fell in [redacted] bathroom attempting to use the bathroom. On 5/30/22, resident #6 reported to staff members [redacted] had swelling and pain in her left arm and elbow; however, an X-ray of the resident’s left arm and elbow was not ordered until 6/3/22, and not completed until 6/6/22. Resident #6 was admitted to the home on 5/28/22; however, as of 6/21/22, no assessment was completed for the resident.

Plan of Correction

Accept

Untimely medical care was provided due to Resident #1’s [redacted] and [redacted] strong opposition to us sending Resident #1 to the hospital and because [redacted] injury appeared to be a small cut above the eye. Results of the assessment did not indicate any other injury at that time. Med Tech and Nurses will receive re-education as to how to assess a resident and determining the resident’s need for further treatment at a hospital by 8/15/22 and a copy of the training will be kept. Resident # 1’s assessment will be updated and resident #6’s assessment will be completed by 7/26/22 and will reflect their medical care needs and the plan to secure medical care. All resident assessments and support plans for current residents will be reviewed by a designated staff person by 7/31/22 to ensure all medical needs and the plan to secure medical care are documented under this regulation. A designated staff person shall review the records of all current residents to ensure each resident has an assessment completed in its entirety within 15 days of admission. The Healthcare Director or Designated person will check the initial assessment for new residents against the Medical Evaluation to ensure correct diagnosis and that resident needs are properly documented. Assessment due dates will be reviewed at Stand Up meetings Monday through Friday to ensure the assessment is completed within 15 days of admission under this regulation. The Resident Administrative Checklist will be used to ensure an assessment is completed in its entirety within 15 days of admission for all newly-admitted residents. Copies of the completed Resident Administrative checklist shall be kept in each resident’s record. All staff persons involved in the admission process were educated on the Resident Administrative checklist 7/15/22. All staff persons involved in the admission process will be educated on the processes under the POC by 7/31/22. Documentation of the education shall be kept. The Executive Director or Designated Person will audit the processes under this POC monthly to ensure completion and results of this audit will reviewed at the monthly Quality Management Meeting x 3 months and every 6 months thereafter.

Completion Date: 08/15/2022 Licensee’s Proposed Date for POC Implementation

[redacted] 9/2/22  
Not Implemented

182b - Prescription Medication

1. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

**182b - Prescription Medication (continued)**

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

**Description of Violation**

*Staff person A, the home's administrator, is not qualified to administer medications in accordance with 2600.182b; however, staff person A administered medications to numerous residents on 6/16/22 and 6/17/22, to include the following:*

*Resident #3's 8:00 a.m. medications on 6/16/22, to include:*

- *Eliquis-2.5mg tablet*
- *Entresto-24mg/26mg tablet*
- *Escitalopram-10mg tablet*

*Resident #6's 8:00 a.m. medications on 6/16/22, to include:*

- *Advair-100/50 Diskus*
- *Amiodarone HCL-200mg tablet*
- *Atorvastatin-20mg tablet*

*Resident #10's 8:00 a.m. medications on 6/16/22 and 6/17/22, to include:*

- *Diltiazem 24-hour ER-120mg capsule*
- *Escitalopram-10mg tablet*
- *Furosemide-20mg tablet*

**Plan of Correction****Accept**

*A designated staff person shall develop and implement a tracking system of staff persons who are currently qualified to administer medications. The tracking system shall include dates of current trainings and be reviewed during QM meetings to ensure trainings are kept up-to-date in accordance with nursing license requirements, as well as the Department-approved medication administration course. This shall be completed by 8/10/22. Staff Person A, the home's administrator, will complete medication administration training under 2600.190 by 08/15/22. The Home has scheduled medication administration training under 2600.190 to be completed by 8/31/22 for additional staff to be certified in medication administration to support the needs of the residents and community. Documentation of this training and required certification documents under 2600.190 training will be kept on record. All Administrators hired will receive medication training within 60 days of hire. A designated staff person will update the Personnel Employee Record checklist by 7/31/22 to include this requirement and the Business Office Manager or Designee will be responsible to ensure completion of this training. Documentation of completed training and required medical administration certification will be kept in the Administrator's staff record. Compliance to this POC will be reviewed at the monthly Quality Management Meeting on a quarterly basis to start by 8/31/22. All staff involved in the hiring process will be educated on this POC and responsibilities by 7/31/22. Documentation of this education will be kept. Staff will agree to upon hire in writing that only qualified staff persons administer medications to residents in accordance with 2600.182 and should they not have that official qualification, they may not administer medications. All current staff will be required to sign this form by 8/15/22 and all new hires will sign this form going forward during the orientation process, which will be kept in each employee record.*

9/2/22

**Completion Date:** 08/15/2022 Licensee's Proposed Date for POC Implementation**Not Implemented**

## 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

On 6/21/22 at 10:01 a.m., the following medications were unlocked, unattended and accessible in resident #10's bedroom:

- Fluticasone Propionate nasal spray
- Deep Sea Saline Spray

## Plan of Correction

Directed

Medications were removed from resident #10's room during the time of inspection. The Healthcare Director or Designee will be responsible to ensure upon resident admission that no prescription medications, OTC meds, CAMs or syringes are unlocked, unattended or accessible in a resident's room. If the resident is unable to self-administer, these items will be retained and locked in a Harmony Medication Room. All medication technicians were re-trained on medication safety and medication administration requirements on 7/20/22, that included education as to medications being left unlocked and unattended in a resident's room. Upon admission, the Healthcare Director or Designee will be responsible to ensure that any self-administering resident has a locking box or drawer to keep their medications secured and that they are in fact secured the day of admission. (DIRECTED: No resident shall self-administer medications until they are assessed as capable by a physician, physician's assistant or certified registered nurse practitioner in accordance with 2600.181c. Documentation of the completed assessment shall be kept. LM 8/2/22). The Executive Director and or Designee will audit rooms of new admissions the day of move in to ensure compliance to this regulation monthly x 2 and then quarterly thereafter. This process will be reviewed for effectiveness at the monthly Quality Management meeting by 8/31/22 x 2 and to decrease to every 6 months thereafter. A designated staff person will interview at least 5 residents per month for 6 months to ensure residents receive their medications as prescribed, and that staff assistance with medication administration is provided to the resident, if necessary. During the resident interviews, the designated staff person shall also inspect the resident's bedroom to ensure there are no medications that are unlocked and accessible. Documentation of the interviews shall be kept.

9/2/22

Completion Date: 08/31/2022 Licensee's Proposed Date for POC Implementation

Not Implemented

## 183c - Refrigerated Meds Locked

## 1. Requirements

2600.

183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

## Description of Violation

On 6/21/22 at 9:20 a.m., numerous medications were unlocked, unattended and accessible in the SDCU medication room refrigerator, to include the following:

- 32 syringes of Morphine Sulfate-100/5ml for resident #2
- 4 syringes ABHR-1/25/10mg gel for resident #2

183c - Refrigerated Meds Locked (continued)

- 12 Bisacodyl-10mg suppositories for resident #11

Plan of Correction

Accept

All of the above medications were secured during survey. All staff will be educated on the requirements for locking medication in a refrigerator under this regulation by 8/10/22. Documentation of the education shall be kept. The Healthcare Director or Designee will be responsible to check refrigerators containing medication on each shift to ensure they are locked. Documentation of these checks will be kept. Audits to ensure compliance of this plan of correction will occur twice a week x 4. Audit period will be extended at that time if further episodes of non-compliance are observed in the final audit. This will also be reviewed with all staff during an All Staff Meeting on a quarterly basis and audited for completion at the monthly Quality Management Meeting quarterly x 3. [REDACTED] 9/2/22

Completion Date: 08/10/2022 Licensee's Proposed Date for POC Implementation

Not Implemented

183d - Prescription Current

1. Requirements

2600.

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

Description of Violation

On 6/21/22, resident #6's Ventolin 90mcg inhaler inhaler was present in the medication cart; however, this medication was discontinued on 6/14/22.

Plan of Correction

Accept

The cited medications were removed from the home at the time of inspection. Discontinued medication will be removed by the Nurse, Medication Technician or Healthcare Director from medication carts upon receipt of a discontinuation medication notice from the doctor. Medication carts will be audited weekly by the Nurse, Medication Technician or Healthcare Director to ensure adherence to this process. Medication carts were audited by Express Care Pharmacy on 7/13/22. All medication technicians were re-trained on medication safety and medication administration requirements under this regulation on 7/20/22. Documentation of the education shall be kept. Results of cart audits and compliance to this regulation will be discussed weekly at daily stand up meetings for effectiveness.

Completion Date: 07/31/2022 Licensee's Proposed Date for POC Implementation

Not Implemented

184a - Labeling OTC/CAM

[REDACTED] 9/2/22

1. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #6 is prescribed Advair 100-50 Diskus-Inhale 1 puff into lungs every 12 hours; however, the Advair diskus does not include a pharmacy label and was not marked with resident #6's name.

184a - Labeling OTC/CAM (continued)

Resident #6 is prescribed Breo Ellipta-100mcg/25mcg for inhalation; however, the Breo inhaler does not include a pharmacy label and the inhaler was not marked with resident #6's name.

Plan of Correction

Accept

New pharmacy labels were added to the current medications listed by the pharmacy. A medication cart audit was completed by Express Care Pharmacy on 7/13/22 and medication labels for resident #6 were reviewed to ensure they had been corrected. Medication Cart audits will be conducted quarterly by Express Care Pharmacy and reviewed by the Healthcare Director, Executive Director or Designated Person at the monthly Quality Management meeting on a quarterly basis to ensure effectiveness of these procedures in remaining compliant to this regulation. Medication labels will be checked against the MAR and prescription to ensure accuracy prior to being placed in the medication cart for administration. A Nurse or Healthcare Director will be responsible for this process. All medication technicians were re-trained on medication safety and medication administration requirements under this regulation on 7/20/22. Documentation of the education shall be kept.

Completion Date: 08/15/2022 Licensee's Proposed Date for POC Implementation

[Redacted] /2/22

Not Implemented

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 #1 is prescribed Nitroglycerin 0.4mg tablet-Dissolve 1 tablet under tongue every 5 minutes maximum 3 tablets as needed; however, on 6/21/22, this medication was not available in the home.

On 6/21/22, resident #6 had 29 Tramadol HCL-50mg tablets present in the medication cart; however, the narcotic count sheet for this medication indicated 30 pills were present.

Plan of Correction

Directed

A medication cart audit was completed by Express Care Pharmacy on 7/13/22 at which time all narcotic sheets were reviewed to ensure accuracy. The prescriptions for resident #1 and resident #6 were reviewed to ensure they meet the requirements under this regulation. Resident # 1 passed and all medications were returned to the pharmacy. The Narcotic count for resident #6 was adjusted on the Narcotic count sheet to correct the number of pills present. Staff erred in their documentation on the narcotic sheet. Medication Cart audits by Express Care Pharmacy are conducted quarterly and reviewed by the Healthcare Director, Executive Director or Designated Person. A Nurse or Healthcare Director will be responsible for auditing medication carts weekly starting 7/31/22. Weekly cart audits

185a - Implement Storage Procedures (continued)

include checking the organization of the cart, checking medications stored in a refrigerator, random MAR checks against medication available and no expired medications, for example. (DIRECTED: The weekly audits shall also include ensuring all prescribed medications are present in the home and available for administration in accordance with prescribers' orders. [REDACTED] 8/2/22). Results of weekly cart audits and compliance to this regulation will be discussed weekly at daily stand up meetings for effectiveness. All medication technicians were re-trained on 7/20/22 as to the requirements of documenting narcotic count sheets under this regulation. The Nurse and Healthcare Director will be educated on the requirements under this regulation and responsibilities of this POC by 7/31/22. Documentation of the education shall be kept. Processes under this POC will be reviewed at the Quality Management meeting on a quarterly basis to ensure effectiveness of these procedures in remaining compliant to this regulation.

Completion Date: 07/31/2022 Licensee's Proposed Date for POC Implementation

[REDACTED] 9/2/22

**Not Implemented**

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:

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).

Description of Violation

Resident #1's June 2022 MAR does not include the following prescribed medications:

- Prochlorperazine 10mg tablet-[REDACTED]
- Furosemide 40mg tablet-Take 1 tablet by mouth every day as needed
- Atropine solution 1%-Instill 2 drops under tongue every 4 hours as needed
- Morphine Sulfate 100mg/5ml-Take 0.25ml by mouth or under tongue every hour as needed
- Lorazepam 1mg tablet-Take 1 tablet by mouth or under tongue every 6 hours as needed

Plan of Correction

**Accept**

Resident #1's MAR was updated to include all the medications cited in the violation. A medication cart audit was completed by Express Care Pharmacy on 7/13/22 at which time all MARS were reviewed to ensure accuracy. Weekly cart audits are done in-house to monitor MARS as well. When a new order arrives it is faxed to the pharmacy and

187a - Medication Record (continued)

they update the MAR and then it goes into our medication administration system (accuflo) where a nurse has to approve or reject the order and we would do so checking the paper order against the order in the system (accuflo).MARS will be reviewed by a Nurse or Healthcare Director prior to the medication being placed in the medcart to ensure the MAR includes the prescribed medication. MARS are reviewed for accuracy during medication cart audits conducted by Express Care Pharmacy quarterly and reviewed by the Healthcare Director, Executive Director or Designated Person. The Healthcare Director and Nurse will be educated on the requirements of this regulation and responsibilities under this POC by 7/31/22. Documentation of this education will be kept. Processes under this POC will be reviewed at the Quality Management meeting on a quarterly basis to ensure effectiveness of these procedures in remaining compliant to this regulation. Nurses and medtechs will be re-educated on the new order process by 8/15/22 and record of the training will be kept.

Completion Date: 08/15/2022 Licensee’s Proposed Date for POC Implementation

9/2/22  
Not Implemented

187b - Date/Time of Medication Admin.

1. Requirements

2600.

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

Description of Violation

Resident #1 is prescribed Morphine Sulfate 100mg/5ml-Take 0.25ml by mouth or under tongue every hour as needed. According to the home’s narcotic count sheets, the Morphine Sulfate was administered multiple times to resident #1, to include the following dates/times; however, this medication is not indicated on resident #1’s June 2022 MAR and was not initialed by staff persons as administered:

- 6/9/22 at 3:00 p.m.
- 6/11/22 at 2:00 p.m.
- 6/12/22 at 11:00
- 6/13/22 at 2:00 a.m.
- 6/14/22 at 11:00

Resident #1 is prescribed Lorazepam 1mg tablet-Take 1 tablet by mouth or under tongue every 4 hours as needed. According to the home’s narcotic count sheets, the Lorazepam was administered multiple times to resident #1, to include the following dates/times; however, this medication is not indicated on resident #1’s June 2022 MAR and was not initialed by staff persons as administered:

- 6/11/22 at 3:00 p.m.
- 6/13/22 at 2:00 a.m.
- 6/13/22 at 7:00 p.m.

Plan of Correction

Accept

A medication cart audit was completed by Express Care Pharmacy on 7/13/22 at which time all MARS were reviewed to ensure accuracy. MARS will be reviewed by a Nurse or Healthcare Director prior to the medication being placed in the medcart to ensure the MAR includes the prescribed medication. MARS are reviewed for accuracy during medication cart audits conducted by Express Care Pharmacy quarterly and reviewed by the Healthcare Director, Executive Director or Designated Person. The Healthcare Director and Nurse will be educated on the requirements of this regulation and responsibilities under this POC by 7/31/22. Documentation of this education will be kept. Processes under this POC will be reviewed at the Quality Management meeting on a quarterly basis to ensure effectiveness of these procedures in remaining compliant to this regulation. Staff will be re-educated on the documentation process whereby receipt of a narcotic is completed on the home’s narcotic count sheets as well as

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

the resident's MAR by 8/15/22 and a record of the training will be kept. Weekly audit of narcotic sheets to be done with weekly medcart audit by the nurse or Healthcare Director, to be reviewed at stand up weekly as completed and address any noted issues.

Completion Date: 08/15/2022 Licensee's Proposed Date for POC Implementation

9/2/22  
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 #3 is prescribed Tramadol 50mg tablet-Take ½ tablet 1 time daily 30 minutes before therapy; however, this medication was not administered to resident #3 daily from 6/1/22 through 6/21/22.

Resident #6 was admitted to the home on 5/28/22; however, no medications were administered to the resident until 5/31/22. Resident #6 is prescribed numerous medications, to include:

- Amiodarone HCL 200mg tablet-Take 1 tablet by mouth every day
- Atorvastatin 20mg tablet-Take 1 tablet by mouth every day
- Clopidogrel 75mg tablet-Take 1 tablet by7 mouth every day

On 6/3/22, resident #6 was prescribed Guaifenesin ER 600mg tablet-Take 1 tablet by mouth every 12 hours for 7 days; however, according to resident #6's June 2022 MAR, the 1st dose of the medication was not administered until 8:00 p.m. on 6/8/22, and the last dose was administered at 8:00 p.m. on 6/10/22. and was not administered for 7 days. On 6/17/22, resident #6 was prescribed Guaifenesin ER 600mg tablet-Take 1 tablet by mouth every 12 hours; however, the medication was not administered at all from 6/17/22 through 6/21/22.

According to resident #6's June 2022 MAR, resident #6 was not administered numerous medications on 6/8/22, to include:

- Amiodarone HCL 200mg tablet-Take 1 tablet by mouth everyday
- Clopidogrel 75mg tablet-Take 1 tablet by mouth everyday
- Furosemide 40mg tablet-Take 1 tablet by mouth everyday
- Advair 100-50 Diskus-Inhale 1 puff into lungs every 12 hours

On 6/8/22, resident #6 was prescribed, "Consult PT/OT RE: evaluate & treat weakness/ambulatory dysfunction"; however, resident #6 did not receive any PT/OT services as of 6/21/22.

According to resident #10's May 2022 MAR, resident #10 was not administered the following medications on 5/26/22:

- The 8:00 p.m. dose of Preservation Areds-Take 1 tablet and chew 2 times a day
- The 12:00 p.m., 4:00 p.m. and 8:00 p.m. doses of Systane gel eye drops-Instill 1 drop into affected eye 4 times a day

**Plan of Correction****Directed**

The root cause for each citation above is that we required additional staff to be med tech trained to support the medication administration needs of our residents, which resulted in the missed medications or wrong time of their administration. Additional staff have been med tech certified as of recent and additional staff to med tech certified by 8/15/22. All certified medications technicians and nurses of the Home will receive re-education by 8/15/22 as to the requirements of following directions of the prescriber under this regulation. Documentation of this education will be kept. Daily auditing of medication administration will be done by the Healthcare Director or Designee starting

187d - Follow Prescriber's Orders (continued)

8/1/22 to ensure all directions of the prescriber are followed and any discrepancies will be reported to the Executive Director immediately. (DIRECTED: The daily audits shall include a review of all resident medications to ensure all medications are present in the home and available for administration in accordance with prescribers' orders. 8/2/22). This will be done through our accuflo system that has the ability to report this data to us daily. The Healthcare Director will be educated as to the requirements of this regulation and the responsibilities under this POC by 8/1/22 and documentation will be kept. This process will be audited at the Daily Stand Up meeting that takes place Monday through Friday each week and reviewed at the monthly Quality Management meeting by 8/31/22 x 3 for effectiveness.

DIRECTED: Within 72 hours of receipt of the plan of correction: A designated staff person shall consult with resident #6's physician to determine if resident #6 still requires PT/OT services as indicated by resident #6's physician order, dated 6/8/22. If resident #6 still requires PT/OT services, a new order shall be obtained from the resident's physician and PT/OT services shall begin. 8/2/22

Completion Date: 08/31/2022 Licensee's Proposed Date for POC Implementation

9/2/22  
Not Implemented

191 - Resident Right to Refuse

1. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Residents #3 and #6's resident records do not included documentation indicating residents #3 and #6 have been educated on their right to question or refuse medication if they believe there may be a medication error.

Plan of Correction

Accept

Resident #3 and #6 will be educated as to their rights under this regulation by 7/31/22. Documentation will be kept. All current resident files will be audited by the Business Office Manager, Executive Director or Designated Person to ensure documentation of the resident's right to refuse is present by 7/31/22. All new admissions will be made aware of their Right to Refuse at time of contract signing and documentation will be kept as part of the contract in the Resident's Record. The Resident Administrative Checklist will be altered by 8/10/22 to include Resident Right to Refuse and will be part of the Business Office review of the Resident's Record on the day of contract signing. All staff persons involved in the admission process will be educated on this POC by 7/31/22 and documentation of this education will be kept. Audits of new resident contracts will be conducted monthly by the Executive Director, Business Office Manager or Designated Person and results will be reviewed at the monthly Quality Management Meeting by 8/31/22 x 3 and decrease to every 6 months thereafter to ensure compliance to this regulation 9/2/22

Completion Date: 08/10/2022 Licensee's Proposed Date for POC Implementation

Not Implemented

224a - Preadmission Screen Form

1. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

No preadmission screening was completed for resident #1, who was admitted to the home on [redacted].

224a - Preadmission Screen Form (continued)

No preadmission screening was completed for resident #3, who was admitted to the home on [REDACTED].

No preadmission screening was completed for resident #6, who was admitted to the home on [REDACTED].

Plan of Correction

Directed

All current records were reviewed to ensure they have a pre-admission screening on 7/31/22. Resident #1, #3 and #6 preadmission screen forms will be completed by 7/31/22. All current resident prescreens will be reviewed by the Healthcare Director, Executive Director or Designated Person for accuracy by 7/31/22. Pre-admission screenings for new admissions will be reviewed by the Healthcare Director or designated person prior to move in for accuracy. The Resident Administrative Checklist will be utilized to ensure pre-admission screenings are complete and placed in the business office file at time of contract signing. (DIRECTED: Copies of the completed new admission checklists shall be kept in each resident's record. [REDACTED] 8/6/22). All staff persons involved with the admission process will be educated on the requirements of this regulation and POC responsibilities by 7/31/22. Documentation of the education shall be kept. Pre admission screenings for new residents to be reviewed weekly at Daily Stand up meeting to ensure compliance to this plan of correction x 2 months, at which time results will be reviewed for effectiveness and if additional audits are necessary, the audit period will be extended.

Completion Date: 08/02/2022 Licensee's Proposed Date for POC Implementation

[REDACTED] /2/22  
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

No assessment was completed for resident #1, who was admitted to the home on [REDACTED]

No assessment was completed for resident #6, who was admitted to the home on [REDACTED]

Plan of Correction

Accept

Resident #1 and #6's assessment will be updated 7/31/22. A designated staff person will review all current resident records by 7/31/22 to ensure an assessment has been completed in its entirety. Assessment due dates will be reviewed at Stand up meetings Monday through Friday along with Resident Administrative Checklists to ensure the assessment is completed within 15 days of admission under this regulation. All staff persons involved in the admission process will be educated on this new process and the Resident Administrative checklist as part of the POC by 7/31/22. Documentation of the education shall be kept. The Executive Director or Designated Person will audit this process monthly to ensure completion and results of this audit will reviewed at the monthly Quality Management Meeting by 8/31/22 x 3 months and every 6 months thereafter. Copies of the completed Resident Administrative checklists shall be kept in each resident's record.

Completion Date: 07/31/2022 Licensee's Proposed Date for POC Implementation

[REDACTED] 9/2/22  
Not Implemented

227d - Support Plan Medical/Dental

1. Requirements

227d - Support Plan Medical/Dental (continued)

2600.

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

Description of Violation

Resident #10 fell in the home on 5/8/22 and was ordered home health services for wound care, and is currently receiving hospice services; however, however, resident #10's support plan, dated [REDACTED], does not include these services or the frequency of these services.

Plan of Correction

Accept

Resident #10 support plan will be updated by 7/31/22 to meet the requirements under this regulation. Current residents will have their support plan reviewed by the Healthcare Director or Designated Person to ensure all care needs and services are accurately documented by 07/31/22. Resident support plans will be updated as resident care needs change through the use of the Shift Report Log. A medtech or nurse will log any changes in resident care needs, which will be reviewed by the healthcare director daily so that care plans can be updated to reflect these changes. All clinical staff persons will be re-educated on this new procedure by 8/15/22. Weekly x 8 an audit will be performed to ensure changes on the shift log report have been updated on resident support plans. Results of these audits will be reviewed at the Monthly Quality Management Meeting by 8/31/22 x 3 months to ensure compliance to this regulation has been met.

Completion Date: 08/31/2022 Licensee’s Proposed Date for POC Implementation

[REDACTED] 9/2/22

Not Implemented

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 #3's support plan, dated [REDACTED] is not signed by the assessor. Also, resident #3's support plan is not signed by resident #3 and does not indicates if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #10's support plan, dated 2/24/22, is not signed by the assessor. Also, resident #10's support plan is not signed by resident #10 and does not indicates if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction

Accept

The Healthcare Director or Designated Person will review and update Resident #3's and #10's support plans and will be signed by the assessor and any individual who participates in the development of the support plan by 7./31/22. These residents did not participate, which will be corrected on the support plan, initialed and dated by the person updating the support plan. All current resident support plans will be reviewed by 7/31/22 for signature and date. Support plans will be reviewed for compliance to this regulation at Stand up meetings Monday through Friday when the Resident Administrative Checklist is completed indicating support plans has met the 15 day completion post

227g -Support Plan Signatures (continued)

admission requirement. All staff persons involved in the admission process will be educated on this new process and requirements under this regulation by 7/31/22. Documentation of education will be kept. he Executive Director or Designated Person will audit this process monthly to ensure completion and results of this audit will reviewed at the monthly Quality Management Meeting by 8/31/22 x 3 months and every 6 months thereafter. Copies of the completed Resident Administrative checklists shall be kept in each resident's record.

Completion Date: 08/15/2022 Licensee's Proposed Date for POC Implementation

9/2/22  
Not Implemented

231b - Medical Evaluation

1. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the home's SDCU on [redacted] however, resident #1's medical evaluation was completed on [redacted], which exceeds 60 days prior to admission. Also, resident #1's medical evaluation, dated [redacted] does not indicate the need for resident #1 to be served in the SDCU.

Resident #3 was admitted to the home's SDCU on [redacted] however, resident #3's medical evaluation was completed on 5/3/22.

Plan of Correction

Accept

New Medical Evaluations will be obtained for #1 and #3 under this regulation by 7/31/22. All current resident Medical Evaluations will be reviewed by a designated staff person for compliance to this regulation by 7/31/22. Medical Evaluations for new admissions will be reviewed by the Healthcare Director, Executive Director or Designated Person prior to admission for compliance to this regulation. Medical Evaluation requirements under this regulation will be reviewed at Stand up meetings Monday through Friday when the Resident Administrative Checklist is completed indicating the resident record has been completed in its entirety. All staff persons involved in the admission process will be educated on this new process and requirements under this regulation by 7/31/22. Documentation of education will be kept. The Executive Director or Designated Person will audit this process monthly x 3 to ensure compliance to this POC. Results of this audit will be reviewed for effectiveness at the monthly Quality Management Meeting by 8/31/22 x 3 months . Copies of the completed Resident Administrative checklists shall be kept in each resident's record.

Completion Date: 07/31/2022 Licensee's Proposed Date for POC Implementation

9/2/22  
Not Implemented

231c - Preadmission Screening

1. Requirements

2600.

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

Description of Violation

A written cognitive preadmission screening was not completed for resident #1, who was admitted to the home's SDCU on [redacted]

231c - Preadmission Screening (continued)

A written cognitive preadmission screening was not completed for resident #3, who was admitted to the home's SDCU on [REDACTED]

**Plan of Correction**

**Accept**

The preadmission cognitive screening will be completed for residents #1 and #3 by 7/31/22. The Executive Director, Business Office Manager or Designee will utilize the Resident Administrative Checklist to ensure pre-admission cognitive screenings are complete and placed in the business office file at time of contract signing beginning 7/13/22, within 72 hours of admission. All staff persons involved with the admission process were educated on the requirements of this POC and responsibilities on 7/20/22. Documentation of the education shall be kept. Copies of the completed Resident Administrative Checklist shall be kept in each resident's record. All current resident records will be reviewed by the Healthcare Director, Executive Director or Designated Person to ensure a pre admission screening has been completed by 7/31/22. All new admissions shall have pre-admission screenings completed prior to admission by the Healthcare Director, Executive Director or Designated Person. Preadmission screenings will be reviewed at Stand up meetings Monday through Friday when the Resident Administrative Checklist is completed indicating the resident record has been completed in its entirety. Pre-admission screenings will be audited weekly x 2 months by the Executive Director or Designated Staff Person for compliance to this regulation and results will be reviewed at Monthly Quality Management meetings x 2 months and every 6 months thereafter.

Completion Date: 08/15/2022 Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] /2/22

231e - No Objection Statement

1. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

There is no statement present in resident #3's record indicating the resident and the resident's designated person have not objected to resident #3's admission to the home's SDCU. Resident #3 was admitted to the home's SDCU on [REDACTED]

**Plan of Correction**

**Accept**

The Designated persons for resident # 3 and resident #3 will acknowledge in writing that they do not object to the admission to the SDCU by 7/31/22. All current SDCU resident files will be audited by the Healthcare Director, Executive Director or Designated Person to ensure a no objection statement has been completed, to be done by 7/31/22. All new admissions will complete a no objection statement at time of contract signing. All staff persons involved in the admission process were educated on the requirements of this regulation and responsibilities under the POC on 7/15/22. Documentation of the education shall be kept. All contract paperwork to include this no objection statement will be reviewed by the Business Office Manager, Executive Director or Designated Person at or within 72 hours of admission to ensure completion. Results of this audit will be reviewed at the monthly Quality Management Meeting x 2 months and every 6 months thereafter. The Resident Administrative checklist will be reviewed at daily Stand Up meeting Monday through Friday to ensure documentation is obtained from the resident and the resident's designated person that they do not object to the admission or transfer to the secured dementia care unit. Copies of the completed Resident Administrative checklists shall be kept in each resident's record. All staff persons involved in the admission process

231e - No Objection Statement (continued)

were educated on the new checklist 7/15/22. Documentation of the education shall be kept.

Completion Date: 08/15/2022 Licensee's Proposed Date for POC Implementation

Not [redacted] /22 mented

234a - Admission Support Plan

1. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

No support plan was completed for resident #1, who was admitted to the home's SDCU on [redacted]

Resident #3 was admitted to the home's SDCU on [redacted]; however, resident #3's support plan was not completed until 6/9/22.

Plan of Correction

Accept

Resident #1 was completed [redacted] and #3's support plan will reviewed for accuracy and any necessary updates will be made by 7/31/22. The Healthcare Director was educated on this POC 7/15/22. All current SDCU resident records will be audited for completed support plans by 7/31/22. The Healthcare Director, Executive Director or Designated Person will be responsible. The Resident Administrative record will be utilized to ensure a support plan is completed in its entirety within 72 hours of the admission, or within 72 hours prior to a resident admission to the secured dementia care unit. Assessment and support plan due dates will be reviewed at daily stand up meetings to ensure compliance to this regulation starting 7/15/22. This POC will be reviewed at the Monthly Quality Management meeting x 3 and then quarterly thereafter. Copies of the completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on this POC and responsibilities by 7/15/22. Documentation of the education shall be kept.

Completion Date: 08/15/2022 Licensee's Proposed Date for POC Implementation

Not [redacted] 9/2/22 mented