pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

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

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

Dear [redacted]

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

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

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

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

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

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

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

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

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

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

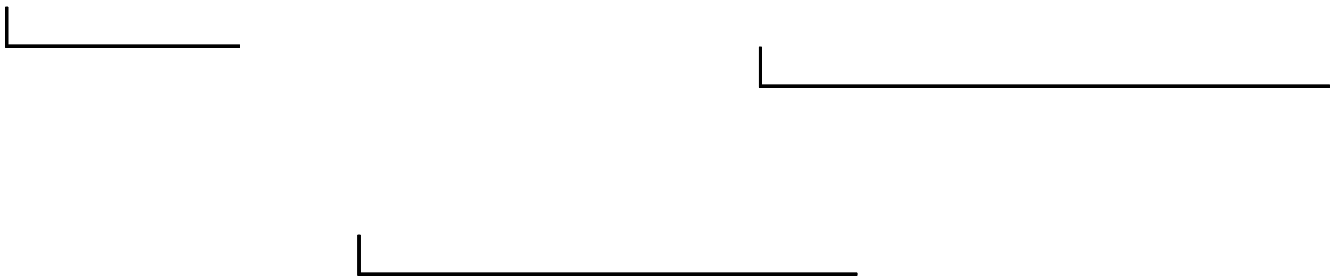
Sincerely,

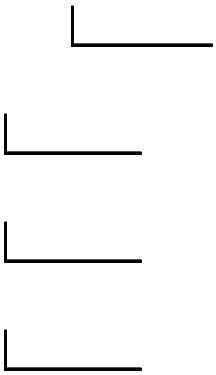
Jamie L. Buchenauer

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]





3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 7/18/22, the licensing inspection summaries, dated 6/2/21 et. al., and 9/17/21, were not posted in a public and conspicuous place in the home.

Plan of Correction ***Accept***

Fixed on site 7/18/2022. Most current inspection summaries dated 6/2/21 and 9/17/21 were posted in a public and conspicuous place which is the front main entrance of the build. (See attached picture)
Admin/designee will audit one a week for one month and monthly thereafter. Documentation will be kept.
Admin/designee started audits on 8/26/2022. Admin/assist admin will post all new LIS's issued by the department moving forward.

Completion Date: *08/29/2022* Licensee's Proposed Date for POC Implementation [redacted] 10/14/22

Document Submission ***Implemented***

Fixed on site 7/18/2022. Most current inspection summaries dated 6/2/21 and 9/17/21 were posted in a public and conspicuous place which is the front main entrance of the build. (See attached picture)
Admin/designee will audit one a week for one month and monthly thereafter. Documentation will be kept.
Admin/designee started audits on 8/26/2022. Admin/assist admin will post all new LIS's issued by the department moving forward.

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

During the month of July 2022, numerous residents did not receive their medications as prescribed, to include residents #6, #7, #8, #9 and #10; however, these medication errors were not reported to the Department until 7/19/22.

Plan of Correction ***Directed***

Immediately on 7/19/2022 designee did an incident report for resident #6, #7, #8, #9 and #10. On 9/5/2022 a staff meeting will be held on regulation 2600.188. During the staff meeting every staff member will receive a copy of the policy and procedure of reporting incidents, reporting medication errors, to ensure timely reporting to the department. Documentation will be kept. Admin or designee will run a report of missed meds daily on tabula pro, any medication errors that are founded will be reported to department immediately. Immediate staff education will be provided as needed as related too any missed medications. Reportable incident will be file in the require time frame. All notification will be made to POA and MD. Documentation will be kept.
Reportable incidents will be review at ever quarterly quality management meetings. Documentation will be kept.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review all internal incidents and conditions daily to ensure all reportable incidents and conditions indicated in 2600.16a are

16c - Written Incident Report (continued)

reported to the Department within 24 hours. [redacted] *9/2/22.*

[redacted] 10/14/22

Completion Date: *08/29/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

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 7/18/22 at 11:08 am, the computer on the 3rd floor medication cart was unlocked and unattended. Multiple resident records were accessible on the unlocked computer, to include residents #3 and #4's face sheets, July 2022 medication administration records (MAR's), and physician orders.

REPEAT VIOLATION: 6/23/2021

Plan of Correction ***Accept***

Immediately on 7/18/2022 staff member was educated by department representive on the important of confidentiality.
Med tech training related to confidentiality of records will be held on 9/5/2022. Documentation will be kept.
Admin/designee will conduct rounds 5 times a week for one month during random med passes to ensure med cart computers are locked and no resident information is excess able. After four weeks rounds will be conducted three times a week for one month and two times a week thereafter.
Immediate staff education will be provided as needed. Documentation of rounds will be kept.
The settings on the med tech computers have been changed to time out after 30 seconds of any inactivity.

Completion Date: *09/05/2022* Licensee's Proposed Date for POC Implementation [redacted] 10/14/22

Document Submission ***Implemented***

Immediately on 7/18/2022 staff member was educated by department representive on the important of confidentiality.
Med tech training related to confidentiality of records will be held on 9/5/2022. Documentation will be kept.
Admin/designee will conduct rounds 5 times a week for one month during random med passes to ensure med cart computers are locked and no resident information is excess able. After four weeks rounds will be conducted three times a week for one month and two times a week thereafter.
Immediate staff education will be provided as needed. Documentation of rounds will be kept.
The settings on the med tech computers have been changed to time out after 30 seconds of any inactivity.

51 - Criminal Background Check

1. Requirements

2600.

51 - Criminal Background Check *(continued)*

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

No Pennsylvania criminal background check was completed for staff person A, hired on [redacted]

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

Plan of Correction ***Directed***

Immediately on 7/18/2022 staff member A received a PA background check.
A new hire checklist has been created to include a list of all documents that are required prior to new employee start date. The new hire checklist will be implemented for any new hire effective 8/30/22. Education will be provided to all management on 8/31/22 on the new hire checklist and completion of background check prior to start date. (DIRECTED: Documentation of the education shall be kept. [redacted] *9/2/22). The checklist will be review by admin/designee prior to any new employee being given a start date.*
An audit of all employee records will be conducted by admin/designee ~~within 60 days of POC.~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] *9/2/22) (DIRECTED: Within 30 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 a Pennsylvania criminal background check completed. Documentation of the audits shall be kept.* [redacted] *9/2/22).*

[redacted] 10/14/22

Completion Date: *08/30/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

57d - Waking Hours

1. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

The home is required to provide a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs.

On [redacted]*, there were 82 residents in the home, including 28 residents with mobility needs, requiring a total minimum of 82.5 hours of direct care staffing during waking hours. On this day, only 81 hours of direct care staffing were provided during waking hours.*

On [redacted] *there were 78 residents in the home, including 26 residents with mobility needs, requiring a total minimum of 78 hours of direct care staffing during waking hours. On this day, only 76.5 hours of direct care staffing were provided during waking hours.*

On [redacted] *there were 78 residents in the home, including 26 residents with mobility needs, requiring a total minimum of 78 hours of direct care staffing during waking hours. On this day, only 67 hours of direct care staffing were provided during waking hours.*

57d - Waking Hours (continued)

Plan of Correction ***Directed***

Beginning 8/29/2022 a daily meeting will be held Monday thru Friday to include admin, assist admin and RCC. A current day schedule as well as the next day schedule will be reviewed to ensure that adequate staffing is met.
To ensure compliance, the admin/ designee will run a weekly report from tabula pro to audit staffing hours for the previous week. Documentation of the audits will be kept on the weekly report.

DIRECTED: Within 72 hours of receipt of the plan of correction: A designated staff person shall review the home's direct care staffing schedule daily to ensure adequate staffing is present in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. When regularly scheduled direct care staff persons are absent, the home shall arrange for substitute personnel who meet the direct care staffing requirements in accordance with 2600.61 to ensure adequate staffing coverage in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. Documentation of the daily review of the direct care staffing schedule shall be kept, which includes the number of residents present in the home, the number of residents with mobility needs, and the actual hours worked for each direct care staff person and substitute personnel. [redacted] *9/2/22*

[redacted]10/14/22

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

Not Implemented

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Residents #4, #9, and #10 utilize bed enablers on their beds; however, the bed enablers have a 11 ½" X 9" opening and are uncovered, posing an entrapment hazard.

REPEAT VIOLATION: 9/17/2021; 6/23/2021; 6/2/2021, et. al.;

Plan of Correction ***Accept***

On 9/1/2022 nine new enabler cane's were ordered (see attached document) that are called "Vive Bed Cane-Stand Assist Bar" that will replace all enabler bars in the community. Estimated time of delivery will be 9/28/2022. Once delivered, enabler cane will replace all previous equipment. Receipts will be kept.
Walden View paid for all the replacement enabler cane. Moving forward any resident that requires an enable cane it will be the cost of the families.
Daily checks will be added to the task list for staff to confirm that the canes are secure and working properly. Documentation will be kept starting 9/30/2022
Maintenace will also conducted a monthly walk-thru to ensure the canes are secure. Documentation will be kept 9/30/2022.
While waiting on delivery, current enabler bar's will have a cover and will be added to task list to confirm covers are clean and in good repair.

[redacted]0/14/22

Completion Date: *09/30/2022* Licensee's Proposed Date for POC Implementation

Not Implemented

82c - Locking Poisonous Materials

1. Requirements

2600.

82c - Locking Poisonous Materials *(continued)*

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 7/18/22, there was a 32 oz. bottle of Lysol toilet bowl cleaner, approximately 1/2 full, present in the women's bathroom next to the arena room, with a manufacturer's label indicating, "Contact poison control if ingested". Not all residents have been assessed as safe around poisons including, residents #1 and #2.

Plan of Correction ***Accept***

On 7/18/2022 the poisonous materials were removed immediately.
On 8/31/2022 housekeeping educated on removal of all poisonous materials form all bathroom and any common area. This was added to housekeeping daily assignment sheets for documentation. All staff will be educated on poisonous material by 9/5/22, documentation will be kept. Housekeeping assignment sheets are handed in daily to assist admin. Documentation will be kept.

10/14/22

Completion Date: *09/05/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/18/22 at 4:00pm, there were no paper towels, mechanical hand dryer or other sanitary means of hand drying in the shared bathroom of residents #6 and #13.

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

Plan of Correction ***Directed***

Immediately on 7/18/2022 housekeeping put paper towels in resident #6 and resident #13 shared suite.
On 8/29/2022 staff meeting will be held to educate on sanitary conditions. (DIRECTED: Documentation of the education shall be kept. [redacted] 9/2/22).
Within 30 days of 8/29/2022 RCA will be trained on the task list documentation in tabula pro. RCA will had a daily shift checklist of different violations/regulation to help ensure that Walden's View stays in compliance with BHSL. Staff will also receive training on the current violation ensuring the understanding of the regulations. (DIRECTED: The staff training shall occur within 15 calendar days of receipt of the plan of correction. Documentation of the education shall be kept. [redacted] 9/2/22). RCA will document in the task list in tabula pro that there are means of hand drying present. Weekly report will be printed and reviewed by admin/designee.
Housekeeping will also have this added to their daily checklist.
Maintenace will also do monthly walk-thru to ensure paper towel Despencer are in working order. (DIRECTED: The monthly walkthroughs shall begin within 5 calendar days of receipt of the plan of correction and shall include a walkthrough of the entire home to ensure sanitary conditions are maintained. [redacted] 9/2/22)

[redacted] 10/14/22

Completion Date: *09/29/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

86b - Bathroom

1. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 7/18/22, no exhaust fans were present in the common men's and women's bathrooms next to the arena room. Neither bathroom has an operable window.

Plan of Correction ***Accept***

Electrician [redacted] *with company* [redacted] *was contacted and will be coming within 3 weeks to install exhaust fans in the men and women's restroom by the arena. Receipts will be kept.*
Maintenance did a complete building check of all exhaust fans on 8/26/22. Lobby restroom, [redacted] *are non-operable and will be fixed also. The exhaust fans within the suites* [redacted] *) were fixed and operable on 8/30/22. Additional parts were ordered for the exhaust fan in the lobby restroom and is expected to be completed by 9/9/22.*
Maintenance moving forward will do 8 exhaust fans monthly. Documentation will be kept.

Completion Date: *09/23/2022* Licensee's Proposed Date for POC Implementation [redacted] 10/14/22

Document Submission ***Implemented***

Electrician [redacted] *with company* [redacted] *was contacted and will be coming within 3 weeks to install exhaust fans in the men and women's restroom by the arena. Receipts will be kept.*
Maintenance did a complete building check of all exhaust fans on 8/26/22. Lobby restroom, [redacted] *are non-operable and will be fixed also. The exhaust fans within the suites* [redacted] *) were fixed and operable on 8/30/22. Additional parts were ordered for the exhaust fan in the lobby restroom and is expected to be completed by 9/9/22.*
Maintenance moving forward will do 8 exhaust fans monthly. Documentation will be kept.

95 - Furniture and Equipment

1. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 7/19/22, the toilet in the women's bathroom next to the arena room was not secured to the floor.

Plan of Correction ***Directed***

On 7/19/2022 Maintenance secured toilet to the floor.
Maintenance will conduct a full inspection of all toilets in the facility by 8/26/2022 to ensure they are properly secure and in working order. Monthly inspections will be completed thereafter, checking 8 toilets a month. Documentation will be kept. (DIRECTED: The monthly inspections shall begin within 5 calendar days of receipt of the plan of correction and shall include a walkthrough of the entire home to ensure all furniture and equipment is in good repair, clean and free of hazards. [redacted] *9/2/22).*
Staff will utilize the crew app to notify management and maintenance of any furniture or equipment that is in need of repair. Staff will be educated on 9/5/2022 on the importance of working equipment. (DIRECTED: Documentation of the education shall be kept. [redacted] *9/2/22).*

Completion Date: *09/05/2022* Licensee's Proposed Date for POC Implementation [redacted] 10/14/22

Not Implemented

101j7 - Lighting/Operable Lamp

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 7/18/22, resident #13's bedside lamp was not operable. No other source of lighting that could be turned on/off from bedside was present.

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

Plan of Correction ***Accept***

Immediately on 7/18/2022 a light bulb was placed in lamp.
Maintenace will perform a walk thru of all bedrooms to ensure that operable lighting can be turned on at bedside by 9/15/2022. Documentation will be kept.
Staff trained on regulation 101.J7 on 8/29/2022. Documentation will be kept.
Within 30 days of 8/29/2022 RCA will be trained on the task list documentation in tabula pro. RCA will had a daily shift checklist of different violations/regulation to help ensure that Walden's View stays in compliance with BHSL. Staff will also receive training on the current violation ensuring the understanding of the regulations. RCA will document in the task list in tabula pro that there is operable lighting in all suites. RCA will also ensure that light/lamp is within reach of resident. Weekly report will be printed and reviewed by admin/designee.

[redacted] 10/14/22

Completion Date: *09/29/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

102k - No Common Towel

1. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

On 7/18/22 at approximately 4:00pm, there was a used, unlabeled towel present in the shared bathroom of residents #6 and #13.

Plan of Correction ***Accept***

Fixed on site 7/18/2022. A label was placed on the towel rack for each resident in the shared bathroom for resident #6 and #13.
Staff educated on 8/29/2022 that the use of a common towel is prohibited. Documentation will be kept. On 8/29/2022 staff meeting will be held to educate on sanitary conditions.

102k - No Common Towel (continued)

Within 30 days of 8/29/2022 RCA will be trained on the task list documentation in tabula pro. RCA will had a daily shift checklist of different violations/regulation to help ensure that Walden's View stays in compliance with BHSL. Staff will also receive training on the current violation ensuring the understanding of the regulations. RCA will document in the task list in tabula pro that there are clean towels present and if a shared room, then proper label is in sight. Weekly report will be printed and reviewed by admin/designee. RCA's will remove soil linens after am and pm care and replace with clean linens. 10/14/22

Completion Date: *09/29/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

121a - Unobstructed Egress

1. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 7/18/22, the following exit doors were locked and were unable to be opened:

- *The exit door in the beauty shop*
- *The 2 exit doors from the ground floor sitting room*
- *The 2 exit doors from the private dining room*

Plan of Correction ***Directed***

Staff educated that any egress routes from the building must by unlocked and unobstructed by 8/29/2022. Documentation will be kept.
A panic exit device was placed on the beauty shop door on 7/28/2022. See attached picture. The 2 exit doors within the ground floor sitting area and private dinning room were immediately unlocked. Maintenance /designee will complete a weekly building walk thru to ensure that all exit doors are unlocked. Documentation will be kept. (DIRECTED: The weekly walkthroughs shall begin within 5 calendar days of receipt of the plan of correction. [redacted] 9/2/22).

Completion Date: *08/30/2022* Licensee's Proposed Date for POC Implementation [redacted]0/14/22

Document Submission ***Implemented***

Staff educated that any egress routes from the building must by unlocked and unobstructed by 8/29/2022. Documentation will be kept.
A panic exit device was placed on the beauty shop door on 7/28/2022. See attached picture. The 2 exit doors within the ground floor sitting area and private dinning room were immediately unlocked. Maintenance /designee will complete a weekly building walk thru to ensure that all exit doors are unlocked. Documentation will be kept. (DIRECTED: The weekly walkthroughs shall begin within 5 calendar days of receipt of the plan of correction. [redacted] 9/2/22).

130e - Hearing Impairment

1. Requirements

130e - Hearing Impairment *(continued)*

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident #5 is unable to hear the fire alarm system; however, resident #5 does not have a signaling device approved by a fire safety expert to ensure resident #5 is alerted in the event of a fire.

Plan of Correction ***Directed***

On 7/20/2022 Intelligent electronic systems ordered supplies to install signaling device for resident #5. A certified electrician and IES completed installation on 8/26/2022. Approved by Fire safety expert Tom Bonura. See attached letter. Their are no other residents currently living in the home who require a a signaling device. Moving forward any hearing-impaired resident will not be admitted until proper signaling device is installed.

DIRECTED: Resident #5's signaling device shall be checked during each fire drill by a designated staff person to ensure it is operable. [redacted] 9/2/22).

Completion Date: *08/30/2022* Licensee's Proposed Date for POC Implementation [redacted] 10/14/22

Document Submission ***Implemented***

On 7/20/2022 Intelligent electronic systems ordered supplies to install signaling device for resident #5. A certified electrician and IES completed installation on 8/26/2022. Approved by Fire safety expert [redacted]. See attached letter. [redacted]. Moving forward any hearing-impaired resident will not be admitted until proper signaling device is installed.

DIRECTED: Resident #5's signaling device shall be checked during each fire drill by a designated staff person to ensure it is operable. [redacted] 9/2/22).

131a - Fire Extinguisher

1. Requirements

2600.
131.a. There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

Description of Violation

On 7/18/22, there was no fire extinguisher in the home's attic.

Plan of Correction ***Directed***

On 7/18/2022 maintenance put any operable extinguisher with a minimum 2-A rating in the attic, confirmed by the administrator. Maintenance will ensure that fire extinguishers are checked yearly by a fire safety expert. Admin will put reminder into tabula pro to check all fire extinguishers the following year.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall inspect the home to ensure there is at least one operable fire extinguisher with a minimum 2-A rating on each floor, including the basement and attic, [redacted] 9/2/22

Completion Date: *08/30/2022* Licensee's Proposed Date for POC Implementation [redacted] 10/14/22

Not Implemented

132c - Fire Drill Records

1. Requirements

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

Description of Violation

Multiple residents indicated they did not evacuate to a designated meeting place away from the building or to a fire-safe area during the fire held held on 7/20/22 at 5:25am; however, the home's fire drill records indicate that 76 residents were present in the home at the time of the fire drill and that all 76 residents were evacuated.

Plan of Correction ***Accept***

On 8/19/2022 at 10:19 am a fire drill was conducted with the admin present to ensure that all residents were evacuated to fire safe areas that is in writing from a fire safe expert.
During 9/20/2022 resident council meeting, residents will be reminded of fire safe areas in the home. Staff will be reeducated on fire safe areas by 9/16/2022, documentation will be kept. Maintenance will be reeducated on how to accurately document the fire drill information on the monthly log form, documentation will be kept. (DIRECTED: The education conducted with Maintenance shall be completed by 9/16/22. Documentation of the education shall be kept. [redacted] 9/2/22).
Within 90 days an unannounced fire drill will take place on all 3 shifts to ensure that all staff evacuate all residents to a fire safe area. The admin/designee will be present for all fire drills moving forward to review and ensure accurate documentation of the fire drill.

[redacted] 10/14/22

Completion Date: *09/20/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

132d - Evacuation

1. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home did not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert until 7/27/22. The home exceed the maximum safe evacuation time of 2 minutes, 30 seconds during the following fire drills:

- *12/30/21 at 10:44 am-Evacuation was completed in 3 minutes, 35 seconds*
- *1/26/22 at 3:22 pm-Evacuation was completed in 2 minutes, 40 seconds*
- *3/10/22 at 3:45 pm-Evacuation was completed in 3 minutes*
- *4/15/22 at 10:45 am-Evacuation was completed in 5 minutes, 47 seconds*
- *5/20/22 at 6:04 am-Evacuation was completed in 4 minutes, 18 seconds*
- *6/30/22 at 3:17 pm-Evacuation was completed in 3 minutes, 20 seconds*
- *7/20/22 at 5:25 am-Evacuation was completed in 9 minutes, 25 seconds*

132d - Evacuation *(continued)*

Plan of Correction ***Accept***

Immediately on 7/20/2022 admin notified a fire safe expert [redacted] and scheduled a Fire evacuation time/fire safe area designation training.
Training took place 7/27/2022 to ensure compliance with regulation 132D.
Admin scheduled a reminder in tabula pro for 6/15/2023 to schedule for July of 2023. The admin/designee will be present for all fire drills moving forward to review and ensure all residents are evacuated to a fire safe area within the homes specified time in writing by a fire safety expert (12minutes). During the staff meeting held on 8/29/22 all violations were reviewed and staff was reeducated on fire safe areas within the home.

Completion Date: *08/30/2022* Licensee's Proposed Date for POC Implementation [redacted] 10/14/22

No lemented

132h - Designated Meeting Place

1. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 7/20/22 at 5:25 am, multiple residents indicated they did not evacuate to a designated meeting place away from the building or to a fire-safe area. Residents indicated they heard the fire alarm sound; however, they stayed in their bedrooms and were not evacuated.

Plan of Correction ***Accept***

Immediately on 7/20/2022 a meeting was scheduled with [redacted] for 7/27/2022. Admin/ assist admin will be present for all fire drills moving forward. Admin/assist admin will review all fire drill logs monthly to ensure they are completed accurately. Maintenance departments were re-educated on the proper way to document in the fire log. During the staff meeting on 8/29/22 the LIS was reviewed, and all staff are aware of the fire safe area and all residents are to be evacuated during ALL fire drills. Documentation will be kept.
The next resident council meeting will be 9/20/2022. During that meeting admin/designee will give the fire evacuation policy to each resident and have them sign off at the bottom. Admin/designee will go over the fire evacuation policy with the residents. All resident council meetings moving forward will give a reminder to all residents about the importance of participation and the location of the designated meeting place. Documentation will be kept.

Completion Date: *09/20/2022* Licensee's Proposed Date for POC Implementation [redacted] 10/14/22

Not Implemented

133.1 - Exit Signs

1. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

On 7/18/22, there were no exit sign above the following exit doors:

- *The exit door from the home's beauty salon*

133.1 - Exit Signs (continued)

- *The 2 exit doors from the ground floor sitting room*
- *The exit door from the private dining room*

Plan of Correction ***Accept***

Fix and confirmed by department representive on 7/20/22. See attached picture.
Maintenace was given a copy of regulation 133.1 on 8/17/2022. Maintenace will perform a building walk thru by 9/15/2022 to ensure all exits bare the word "EXIT".
Documentation will be kept. Moving forward maintenance will complete an exit sign inspection quarterly

Completion Date: *09/15/2022* Licensee's Proposed Date for POC Implementation [redacted] 10/14/22

Document Submission ***lemented***

Fix and confirmed by department representive on 7/20/22. See attached picture.
Maintenace was given a copy of regulation 133.1 on 8/17/2022. Maintenace will perform a building walk thru by 9/15/2022 to ensure all exits bare the word "EXIT".
Documentation will be kept. Moving forward maintenance will complete an exit sign inspection quarterly

144c2 - Smoking Area Distance

1. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

On 7/18/22 at 10:28 am, resident #11 was smoking outside of exit door #3, which is not the home's designated smoking area.

On 7/19/22 at 1:45 pm, resident #12 was smoking outside of exit door #5 which is not the home's designated smoking area.

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

Plan of Correction ***Directed***

Both residents were reminded of house rules on 7/18/2022 and 7/19/2022.
On 8/24/2022 revision of smoking policy was completed to reflect the house rules.
Residents #11 and #12 plus 4 additional residents were given a copy of the homes smoking policy and a possible 30-day notice if they can't comply to the house rules on 9/2/2022.
Residents signed off that they understand.
Any new admission from 8/28/2022 that is a smoker will be given a copy off the smoking policy to be kept at bedside.
Staff education on the home smoking policy on 8/29/2022. Documentation will be kept. All smoking resident in the home will have reminders during the med pass. Documentation will be kept on the MAR.
Resident education on the facilities smoking policy will be conducted during resident council meeting on 9/20/2022

144c2 - Smoking Area Distance (continued)

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall conduct walkthroughs of the entire exterior of the home daily for one week then weekly thereafter to ensure all residents, staff and visitors are only smoking in the designated smoking areas. Documentation of the walkthroughs shall be kept.
[redacted]*9/2/22*

[redacted]0/14/22

Completion Date: *09/20/2022* 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 7/18/22 at 3:40 pm, the following medications were unlocked, unattended, and accessible in the shared bedroom of residents #5 and #14:

- *A tube of Hydrocortisone cream*
- *Nystatin powder*
- *A tube of Medi-Honey cream*

On 7/18/22 at 3:53 pm, a bottle of Nystatin powder was unlocked, unattended and accessible in resident #2's bedroom.

On 7/18/22 at 4:00 pm, a bottle of Calamine lotion was unlocked, unattended and accessible in the shared bedroom of residents #6 and #13.

REPEAT VIOLATION: 6/23/2021

Plan of Correction ***Accept***

Med tech training will occur on 9/5/2022. Documentation will be kept.
Immediately a complete sweep was done on 7/21/2022 of all resident's suites ensuring that all medications were locked and not unattended.
Moving forward med techs will be required to check all rooms at the end of the shift. Documentation will be in tabula.
Starting 10/1/2022 all families will be notified of the regulation 183B. Regulation will be sent by 9/20/2022 with Octobers invoices.
Sweeps of all suites will begin 9/1/2022 and will be done weekly for 6 weeks. Upon 100 % accuracy monthly thereafter. Documentation will be kept in tabula pro under ADL and IADL's.
[redacted]10/14/22

Completion Date: *10/01/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

185a - Implement Storage Procedures

1. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 blood glucose checks 4 times a day with each meal and at bedtime. On 7/18/22 at 9:07 pm, resident #1's blood glucose was 230; however, resident #1's blood glucose was documented as 236 on the resident's July 2022 MAR.

Resident #7 is prescribed Novolog Flexpen 100u/ml-Inject subcutaneously 4 times a day before meals and at bedtime in accordance with sliding scale. On 7/18/22 at 5:00 pm, resident #7's blood glucose was 329; however, resident #7's blood glucose was documented as 239 on the resident's July 2022 MAR.

Resident #7 is prescribed Novolog Flexpen 100u/ml-Inject 9 units subcutaneously at with supper. According to resident #7's July 2022 MAR, 0 units of insulin were documented as administered on 7/18/22, 8 units of insulin were documented as administered on 7/16/22, and 10 units of insulin were documented as administered on 7/13/22.

Resident #8 is prescribed Lantus Solostar 100u/ml-Inject 10 units subcutaneously as directed in the morning. According to resident #8's July 2022 MAR, 0 units of insulin were documented as administered on 7/1/22, 7/9/22, 7/10/22 and 7/15/22.

Resident #9 is prescribed Humalog Kwikpen 100u/ml-Inject 10 units subcutaneously 3 times a day before meals. The number of units of insulin administered to resident #9 were incorrectly documented on resident #9's July 2022 MAR on numerous days and times, to include the following:

- *7/1/22 and 7/3/22 at 8:00 am, and on 7/1/22 12:00 pm-20 units of insulin were documented as administered*
- *7/2/22 and 7/3/22 at 12:00 pm-22 units of insulin were documented as administered*
- *7/5/22 and 7/6/22 at 5:00 pm-22 units of insulin were documented as administered*
- *7/16/22 at 5:00pm-8 units of insulin were documented as administered*

Plan of Correction ***Accept***

A double check system has been implemented to ensure accuracy of blood glucose readings. Please see attached. Two certified med techs/designee will verify the readings on glucometers prior to the reading being entered into the MAR.

All med techs responsible for administering insulin will attend a diabetic training held by a certified diabetic educator on 9/6/2022.

Daily glucometer audits have been conducted starting 8/15/2022. see attached audits. Daily glucometer audits will continue to be conducted by the Administrator or designee until 100% compliance is met for 60 days. Any necessary education related to errors discovered through the audits will be provided. Audits will include verifying the correct amount of insulin was administered in accordance with the prescriber's directions and that the amount of insulin administered is properly documented on the MAR. Audits will also include ensuring blood sugar readings are taken in accordance with the prescriber's orders. Documentation of the audits and any education provided will be kept.

After 100% compliance is met for a sixty-day period, glucometer audits will be conducted by the Administrator or designee 5 days per week for 4 weeks. If 100 % compliance is maintained, audits will be conducted 3 times per week ongoing. Documentation of the audits will be kept. If 100 % compliance is maintained, audits will be conducted 3 times per week ongoing. Documentation of the audits will be kept.

Completion Date: *09/06/2022* Licensee's Proposed Date for POC Implementation

[redacted] 10/14/22

Not Implemented

185b - Medication Procedures

1. Requirements

2600.
185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

According to the home's Medication Administration policy, dated 7/8/20, "All controlled substances are counted every shift, (the previous shift med passer and the oncoming shift med passer), to agree on the number of narcotics available." However, on numerous dates in June 2022 and July 2022, only 1 med passer was conducting narcotic counts between shifts.

Plan of Correction ***Directed***

Med tech training will be on 9/5/2022 to go over the important of counting the narcotics at the end of each shift. (DIRECTED: Documentation of the education shall be kept. [redacted]9/2/22).
Starting7/25/2022 all staff must report in the communication app (crew) who they did Narcotic count with. Admin/designee will confirm daily for four weeks. Three times a week for 4 weeks and upon 100% accuracy then monthly thereafter. Documation will be kept. [redacted] 10/14/22

Completion Date: *09/05/2022* Licensee's Proposed Date for POC Implementation **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).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #7 is prescribed Novolog Flexpen 100u/ml-Inject subcutaneously 4 times a day before meals and at bedtime in accordance with sliding scale; however, resident #7's July 2022 MAR does not include the frequency of before meals and

187a - Medication Record (continued)

at bedtime.

Resident #8 is prescribed MAPAP 325 mg-Take 2 tablets by mouth twice a day; however, resident #8's July 2022 MAR indicates MAPAP 650 mg-Take 2 tablets by mouth twice a day.

Plan of Correction ***Directed***

The MARs for residents #7 and #8 were updated to reflect the correct orders. See attached
A complete chart audit of all physician orders will be conducted ~~within 45 days~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] 9/2/22). (DIRECTED: The review of all resident MAR's shall be completed within 30 calendar days of receipt of the plan of correction. [redacted] 9/2/22). by admin/designee to verify orders on the MAR matched all physician orders.
Redlining will be completed 5 times each week starting 9/5/2022 by the Administrator or designee to ensure all new physician orders are accurately recorded on the MAR.
Monthly chart to MAR audits will be conducted by admin/designee in order to ensure continued compliance. Documentation of the audits will be kept.

DIRECTED: Within 15 calendar days of receipt of the plan of correction: All staff persons qualified to administer medications shall be educated on the home's procedures for updating resident MAR's upon receipt of new orders from the prescriber. Documentation of the education shall be kept. [redacted] 9/2/22

10/14/22

Completion Date: *09/05/2022* Licensee's Proposed Date for POC Implementation **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

On 7/3/22 at 8:00 am, numerous medications were not documented as administered on resident #3's July 2022 MAR, to include the following:

- *Clopidogrel 75 mg-Take 1 tablet by mouth once a day*
- *Duloxetine HCL DR 60 mg-Take 1 capsule by mouth once a day*
- *Fludrocortisone 0.1 mg-Take 1 tablet by mouth once a day*
- *Metoprolol tartrate 25 mg-Take ½ tablet (12.5 mg) by mouth once a day*

Resident #3 is prescribed Midodrine HCL 10 mg-Take 1 tablet by mouth 3 times a day; however, this medication was not documented as administered on resident #3's July 2022 MAR at 8:00am on 7/3/22, at 12:00pm on 7/4/22 and at 5:00 pm on 7/1/22 and 7/3/22.

Resident #8 was prescribed Cetirizine HCL 10 mg-Take 1 tablet by mouth once a day. This medication was not administered to resident #8 daily from 7/5/22 through 7/18/22, because it was not available in the home; however, this medication was documented on resident #8's July 2022 MAR as administered on 7/9/22, 7/10/22 and 7/15/22.

Resident #9 is prescribed Fluvoxamine Maleate 100 mg-Take 1 tablet by mouth 2 times a day. This medication was not

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

administered to resident #9 at 8:00 am on 7/4/22 through 8:00 am on 7/5/22, because it was not available in the home; however, this medication was documented on resident #9's July 2022 MAR as administered at 8:00 pm on 7/4/22.

Plan of Correction ***Accept***

A complete med cart audit will be conducted by admin./designee by 9/2/22. Any missing medications have been ordered/replaced. Beginning in September, med carts will be audited monthly by the Administrator/designee. Documentation of the audits will be kept.

Beginning September 1, a random sample of 10 MARS will be audited by the Administrator/designee weekly for 8 weeks to ensure medication administration is properly documented. After 8 weeks, 5 MARS will be audited weekly. Documentation of the audits will be kept.

Moving forward, any medication that is provided by the resident's responsible party, will be ordered by the facility in a timely manner in order to ensure the medication is available. All residents/responsible parties have been notified of the new procedure; please see attached.

The Administrator/designee will run a report daily that will show any missed doses of medication from the previous day. Any missed doses will be investigated by the Administrator/designee to determine the cause of the missed dose. If the medication was not available at the time the medication should not have been administered, the medication will be reordered immediately and, if necessary, sent STAT from the pharmacy to ensure no additional doses are missed. Continued education will be provided to staff as necessary. Documentation of audits and education will be kept.

All staff responsible for ordering and reordering medications have been re-educated on the proper procedure/timeframe for ordering and reordering. Please see attached staff training documentation and policy regarding medication order/reordering.

All med techs have been re-educated 9/5/2022 regarding proper medication administration documentation. Documentation will be kept Please see attached training.

After a thorough investigation by admin/assist admin was done with each staff member that was involved in each medication error, the following was determined to be a lack of understanding/training. Training was done with each staff member individually. Admin/assist admin gave training to each staff member on the importance of following the prescriber's orders and proper documentation. Weekly follow ups for 1 month on all staff members involved in medication error.

10/14/22

Completion Date: *09/05/2022* Licensee's Proposed Date for POC Implementation **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 #1 is prescribed blood glucose checks 4 times a day with each meal and at bedtime; however, resident #1's blood glucose was not checked on 7/3/22 at 5:00 pm.

Resident #3 is prescribed Oxycodone 5 mg-Take 1 tablet by mouth every 4 hours; however, on 7/9/22, resident #3 was administered 1 tablet at 7:55 pm, then another tablet at 8:00 pm. Also, on 7/11/22, resident #3 was administered 1 tablet at 4:37 pm, then another tablet at 7:05 pm.

Resident #6 is prescribed Xarelto 15 mg-Take 1 tablet by mouth once a day in the evening; however, this medication

187d - Follow Prescriber's Orders (continued)

was not administered to resident #6 on 7/16/22.

Resident #7 is prescribed Novolog Flexpen 100u/ml-Inject subcutaneously 4 times a day before meals and at bedtime in accordance with sliding scale; however, resident #7's blood glucose was not checked on 7/5/22 and 7/17/22 at 12:00 pm, and on 7/9/22 at 5:00 pm.

Resident #7 is prescribed Levemir Flextouch 100u-Inject 10 units subcutaneously with lunch; however, this medication was not administered to resident #7 on 7/5/22 and 7/17/22.

Resident #7 is prescribed Novolog Flexpen 100u/ml-Inject 4 units subcutaneously with lunch; however, this medication was not administered to resident #7 on 7/5/22 and 7/17/22.

Resident #8 is prescribed Trulance 3 mg-Take 1 tablet by mouth 1 time a day; however, this medication was not administered to resident #9 on 7/13/22, because it was not available in the home.

Resident #8 was prescribed Cetirizine HCL 10 mg-Take 1 tablet by mouth once a day; however, this medication was not administered to resident #8 daily from 7/5/22 through 7/18/22, because it was not available in the home.

Resident #9 is prescribed Aspirin 81 mg-Take 1 tablet by mouth once a day; however, this medication was not administered to resident #9 on 7/4/22 and 7/5/22, because it was not available in the hme.

Resident #9 is prescribed Baclofen 10 mg-Take 1 tablet by mouth twice a day; however, this medication was not administered to resident #9 on 7/5/22 at 8:00 am, because it was not available in the home.

Resident #9 is prescribed Buspirone HCL 10 mg-Take 1 tablet by mouth 3 times a day; however, this medication was not administered to resident #9 on 7/5/22 at 8:00 am, because it was not available in the home.

Resident #9 is prescribed Fluvoxamine Maleate 100 mg-Take 1 tablet by mouth twice a day; however, this medication was not administered to resident #9 at 8:00 am on 7/4/22 and 7/5/22, as well as at 8:00 pm on 7/4/22, because it was not available in the home.

The following medications were not administered to resident #9 on 7/5/22 at 8:00 am, because they were not available in the home:

- Lisinopril 20 mg-Take 1 tablet by mouth once a day
- Methenamine 1 gm-Take 1 tablet by mouth once a day
- Pantoprazole Sodium 40 mg-Take 1 tablet by mouth once a day
- Potassium CL ER 20 MEQ-Take 1 tablet by mouth once a day

Resident #9 is prescribed Humalog 100u/ml-Inject subcutaneously per sliding scale 3 times a day: 141-180-6 units; 181-220=8 units; 221-260=10 units; 261-350=12 units; Call MD if >450 1 hour after treatment. On 7/12/22 at 5:00 pm, resident #9's blood glucose was 328 and should of been administered 12 units of insulin in accordance with the prescribed sliding scale; however, no insulin was administered to resident #9.

On 7/4/22 at 8:00 pm, the following medications were not administered to resident #10, because they were not available in the home:

187d - Follow Prescriber's Orders (continued)

- *Baclofen 10 mg-Take 1.5 tablets (15 mg) by mouth at bedtime*
- *Trazadone 50 mg-Take 1 tablet by mouth at bedtime*
- *Atorvastatin 40 mg-Take 1 tablet by mouth at bedtime*

Resident #10 is prescribed Furosemide 40 mg-Take 1 tablet by mouth once a day; however, this medication was not administered to resident #10 at 8:00 am on 7/4/22, because it was not available in the home.

Resident #10 is prescribed Carvedilol 25 mg-Take 1 tablet by mouth twice a day; however, this medication was not administered to resident #10 at 5:00 pm on 7/3/22 and 7/8/22, as well as at 8:00 am on 7/4/22 and 7/5/22, because the medication was not available in the home.

Resident #10 is prescribed Docusate Sodium 100 mg-Take 1 capsule by mouth twice a day; however, this medication was not administered to resident #10 at 8:00 pm on 7/4/22, because the medication was not available in the home.

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

Plan of Correction ***Directed***

All med techs will be re-educated regarding proper medication administration, blood glucose monitoring and the requirement to follow physician orders including timeframes specified in the order. This training will occur on 9/5/2022. (DIRECTED: The education shall also include re-education on the home's procedures for re-ordering resident medications prior to the current supply being depleted to ensure resident medications are present in the home and available for administration in accordance with prescribers' orders. Documentation of the education shall be kept. [redacted] 9/2/22).
A complete med cart audit was conducted by admin/designee by 9/2/2022. Any missing medications have been ordered/replaced. Beginning in September, med carts will be audited monthly by the Administrator/designee. Documentation of the audits will be kept
The Administrator/designee will run a report daily that will show any missed doses of medication from the previous day. Any missed doses will be investigated by the Administrator/designee to determine the cause of the missed dose. If the medication was not available at the time the medication should not have been administered, the medication will be reordered immediately and, if necessary, sent STAT from the pharmacy to ensure no additional doses are missed. Continued education will be provided to staff as necessary. Documentation of audits and education will be kept.
Beginning September 1, a random sample of 10 MARS will be audited by the Administrator/designee weekly for 8 weeks to ensure medication administration and blood glucose monitoring is completed properly. After 8 weeks, 5 MARS will be audited weekly. Documentation of the audits will be kept. (DIRECTED: A full medication review shall be completed during the audits to ensure all prescribed medications are present in the home and available for administration. [redacted] 9/2/22).
Starting 7/25/2022 a group in the communication app (crew) was adding titled "Personal Care Med Techs". This group is to alert when a medication is running low are if any issues have occurred. Admin, assist admin and RCC monitor daily.

Resident #1-staff educated on importance of blood sugar checks and proper documentation and following

187d - Follow Prescriber's Orders (continued)

prescribers' orders.
Resident #3-staff educated on the importance of proper documentation of exact time NARC was administered. Also, educated on following prescriber's orders exactly as they are on the MAR.
Resident #6-staff educated on the proper documentation and also, educated on following prescriber's orders exactly as they are on the MAR.
Resident #7-staff educated on the proper documentation and also, educated on following prescriber's orders exactly as they are on the MAR.
Resident #8-Medication/pharmancy policy will be sent to all families as of 10/1/2022
Resident #9-Medication/pharmancy policy will be sent to all families as of 10/1/2022. New blood sugar check policy in place of needing 2 signatures to confirm correct documentation.
All receipts of missing medication arrival will be attached to POC.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall conduct a full audit of residents #6, #7, #8, #9 and #10's medications to ensure all prescribed medications are present in the home and available for administration. Documentation of the audits shall be kept. [redacted] 9/2/22).

DIRECTED: Within 5 calendar days of receipt of the plan of correction: A designated staff person shall review the MAR"s and glucometers for all residents prescribed insulin and blood sugar checks weekly for one month then monthly thereafter to ensure accurate and complete documentation of resident blood sugars and insulin administration is present. Documentation of the audits shall be kept. [redacted] 9/2/22

10/14/22

Completion Date: *10/01/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

225a - Assessment 15 Days

1. Requirements

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

Description of Violation

Resident #1's assessment, dated [redacted], does not include the resident's diagnosis of a traumatic brain injury.

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

Plan of Correction ***Accept***

Any individual who participates to the completion of any assessment will be educated on regulation 225A on 9/1/2022.

This was corrected on 7/19/2022. See documentation. An audit of all resident assessment will be completed by 10/1/2022 by admin/assist admin to ensure all diagnosis are current. Documentation will be kept.
Any assessment completed after 8/28/2022 will be reviewed by admin/designee with in 3 days of completion.

225a - Assessment 15 Days (continued)

Initial and dates will be documented on the bottom of last page to confirm completion. 10/14/22

Completion Date: *10/01/2022* Licensee's Proposed Date for POC Implementation **Not Implemented**

[redacted]

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

Plan of Correction ***Accept***

Immediately on 7/18/22 resident #2's support plan was updated with unable to sign d/t inability to comprehend and sign the form. Any individual who participates to the completion of a support plan will be educated on regulation 227G on 9/1/2022. A full chart audit on all resident support plans will be completed by admin/assist admin by 9/28/2022 to ensure signature or resident wasn't able to participate, decline or refused to sign was documented.

227g -Support Plan Signatures (continued)

Documentation of audit will be kept. Any initial, annual or significant change to support plans that are completed will be reviewed by admin/assistant admin with a signature verifying accuracy, within 72 hours from completion.

Completion Date: *09/28/2022* Licensee's Proposed Date for POC Implementation 10/14/22

Not Implemented

Document Submission

Immediately on 7/18/22 resident #2's support plan was updated with unable to sign d/t inability to comprehend and sign the form. Any individual who participates to the completion of a support plan will be educated on regulation 227G on 9/1/2022. A full chart audit on all resident support plans will be completed by admin/assist admin by 9/28/2022 to ensure signature or resident wasn't able to participate, decline or refused to sign was documented. Documentation of audit will be kept. Any initial, annual or significant change to support plans that are completed will be reviewed by admin/assistant admin with a signature verifying accuracy, within 72 hours from completion.