



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail to: [REDACTED]

E-mailed on: 5/2/23

[REDACTED]
INTEGRACARE ERIE LLC
[REDACTED]

RE: THE RESIDENCE AT PRESQUE ISLE BAY
1012 WEST BAYFRONT PARKWAY
ERIE, PA 16507
LICENSE/COC #: 45350

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on 07/26/22 of the above facility, we have determined that your submitted plan of correction is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[REDACTED]
[REDACTED]
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *THE RESIDENCE AT PRESQUE ISLE BAY* License #: *45350* License Expiration: *03/24/2023*
Address: *1012 WEST BAYFRONT PARKWAY, ERIE, PA 16507*
County: *ERIE* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *INTEGRACARE ERIE LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *09/02/2010* Issued By: *City of Erie*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *66* Waking Staff: *50*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *08/02/2022*

Inspection Dates and Department Representative

07/26/2022 - On-Site: [REDACTED]
07/27/2022 - On-Site: [REDACTED]
07/28/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* Residents Served: *40*

Secured Dementia Care Unit

In Home: *Yes* Area: *Life Stories* Capacity: *22* Residents Served: *15*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *40*
Diagnosed with Mental Illness: *15* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *26* Have Physical Disability: *0*

Inspections / Reviews

07/26/2022 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/02/2022*

09/28/2022 - POC Submission

Submitted By: [REDACTED] Date Submitted: *12/07/2022*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *10/05/2022*

12/01/2022 - POC Submission

Submitted By: [REDACTED] Date Submitted: *12/07/2022*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *12/08/2022*

04/24/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: *12/07/2022*
Reviewer: [REDACTED] Follow-Up Type: *Not Required*

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 7/26/22 at 1:00 p.m., resident #1's interdisciplinary progress notes were unsecure, unattended and accessible in a folder on a cabinet in the kitchenette of the secure dementia care unit (SDCU).

POC Submission

Accept (█ - 11/29/2022)

A locking cabinet has been designated for resident confidential information. Staff was re-educated on where these documents are to be kept unless directly using. This was touched on again during our 8-2022 quarterly meeting and it is part of our orientation.

on 7/26/2022 █ immediately moved resident records to locked closet in memory care unit. Designated by █ Staff has key to closet. Staff educated 7/26/2022 and again at Quarterly meeting on 8/9/2022 ran by █

Licensee's Plan Completion Date: 10/04/2022

Not Implemented (█ - 04/24/2023)

58a - Awake Staff 16 or More

2. Requirements

2600.

- 58.a. If a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home.

Description of Violation

On 7/23/22, 40 residents were present in the home. 4 direct care staff persons were on duty; however, staff person A was asleep from approximately █ and staff person B and staff person C were asleep from approximately █

POC Submission

Directed (█ - 11/29/2022)

Staff members A, B, and C were separated from employment. RWD and myself have been in the building on 3rd shifts to monitor for anyone sleeping. Staff was educated in quarterly meeting as well as one on ones with existing 3rd shift staff.

Staff members A, B, C, were all terminated on █/2022 immediately after █ was notified that they were sleeping on the job. █ reported them sleeping as █ observed them upon a third shift inspection. Staff members A, B, and C were terminated by █. Staff was reminded at Quarterly meeting that sleeping on the job is an immediate termination meeting held on █/2022. █ started one on one training with remaining staff on 8/9/2022 and continues to do so with each new employee. █, resident wellness director, makes periodical visit to second and third shifts to monitor for sleeping. This will be an ongoing practice.

Directed:

Per administrator, resident wellness director began conducting 2nd and 3rd shift monitoring 7/23/22, and

58a - Awake Staff 16 or More (continued)

monitoring is done every 2 weeks, ongoing.

S.Q. 11/29/22

Directed Completion Date: 10/04/2022

Implemented [redacted] - 04/24/2023)

85a - Sanitary Conditions

3. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/26/22 at 12:15 p.m., the inside floor and walls of the mini refrigerator in the 1st floor bistro were covered with sticky substances that appeared to be chocolate sauce and caramel sauce.

On 7/26/22 At 1:20 p.m., the floor of the freezer section of the refrigerator/freezer in the kitchenette area of the SDCU was covered with a sticky substance that appeared to be chocolate sauce.

POC Submission

Directed [redacted] - 11/29/2022)

House keeping staff re-educated on the need to check all refrigerators when cleaning an area even if the area is not being used. The refrigerator in the Bistro was thrown out and a new one ordered.

The freezer in the SDCU kitchenette was cleaned and sanitized. House keeping and staff reminded that all areas must be monitored and kept clean and if when checking temperature in refrigerators or freezers they are to inspect and clean them if necessary and per cleaning schedule.

The mini fridge in the Bistro was thrown away by [redacted] on 7/26/2022. [redacted] spoke day shift house keeper regarding checking and cleaning all refrigerators on 7/27/2022. Education regarding cleaning of refrigerators was also provided at Quarterly meeting on 8/9/2022. This task has been added to the Safety and MaintenanceEnginers automatic system to ensure they are being checked on a weekly basis by SME.

The freezer in the SDCU was cleaned and sanitized by [redacted] EOO on 7/28/2022. Staff and house keeping were reminded on 7/26/2022 and at Quarterly Meeting on 8/9/2022 ran by [redacted] EOO. Cleaning schedule began on 7/27/2022 and is on a weekly rotation and as needed.

Directed:

Per administrator, checking and cleaning mini fridge was added to TEL's on 8/9/22.

[redacted] 11/29/22

Directed Completion Date: 10/04/2022

Not Implemented [redacted] - 04/24/2023)

88a - Surfaces

4. Requirements

2600.

88a - Surfaces (continued)

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

Description of Violation

On 7/26/22 at 11:10 a.m., the handrail on the wall across from the 1st floor common bathroom was pulled away from the wall approximately 1/2", exposing sharp edges of the railing, posing a skin tear hazard.

POC Submission

Directed (████ - 11/29/2022)

The handrail on the wall across from the 1 floor common bathroom was completely removed, re secured with nails and putty applied done by █████ on 7/28/2022. It is flush with the wall with no sharp edges. Building is inspected weekly by the MOD and daily by SME. This is ongoing and was already in place. █████ was educate on 7/26/2022 that any and all repairs need to be done in a timely manor.

Directed:

Per administrator, weekly inspections by MOD and daily inspections by SME began 5/7/22.

████ 11/29/22

Directed Completion Date: 10/04/2022

Not Implemented (████ - 04/24/2023)

92 - Windows

5. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 7/26/22 at 12:00 p.m., there was a 6" x 4" tear in the middle of the screen in the middle-left side window in the 1st floor bistro.

POC Submission

Directed (████ - 11/29/2022)

████ SME replaced screen in Bistro windows on 7/28/2022. Windows are part of the weekly MOD inspection and monitored by the SME on an ongoing basis. █████ EOO inspected the window on 9/2/2022 and 10/1/2022.

Directed:

Per administrator, weekly inspections by MOD and daily inspections by SME began 5/7/22.

████ 11/29/22

Directed Completion Date: 10/04/2022

Not Implemented (████ - 04/24/2023)

95 - Furniture and Equipment

6. Requirements

2600.

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

Description of Violation

On 7/26/22 at 1:15 p.m., the magnetic locking mechanism on the door leading from the SDCU to the outside courtyard was inoperable and would not disengage when the access code was entered on the keypad.

95 - Furniture and Equipment (continued)

POC Submission

Accept (████) - 11/29/2022)

Key pad was adjusted by ██████████ Region SME on 8/31/2022. Key pad to be monitored by SME on a weekly basis starting on 8/31/2022. All key pads inspected on 8/31/2022 and in working order.

Licensee's Plan Completion Date: 10/04/2022

Implemented (████) - 04/24/2023)

101j7 - Lighting/Operable Lamp

7. 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 7/27/22 at 10:00 a.m., resident #1 did not have access to a source of light that could be turned on/off at bedside.

POC Submission

Directed (████) - 11/29/2022)

██████████ SME placed a bedside lamp in resident #1 room on 7/28/2022. All staff reminded at Quarterly meeting on 8/9/2022 ran by ██████████ EOO that all residence must have working light at bedside. Monitoring of bedside light started 7/28/2022 and is ongoing. I inspected all rooms on 9/28/2022 and all residents had bedside lighting. Housekeeping is to note this on weekly cleaning schedule as well as staff when entering rooms.

Directed:

Per administrator, weekly monitoring by housekeeping began 7/28/22.

██████ 11/29/22

Directed Completion Date: 10/04/2022

Not Implemented (████) - 04/24/2023)

105g - Lint Removal and Duct Cleaning

8. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 7/26/22 at 11:45 a.m., there was an approximate 1/2" accumulation of lint in the lint trap of the large facility industrial dryer in the main laundry room.

POC Submission

Directed (████) /29/2022)

The lint trap in the dryer has been cleaned and notes placed on and around the dryer to clean the lint trap with every use. The back of the dryer was serviced by a professional to ensure that any accumulation of lint at the back of the machine and in the exhaust line was removed. This now in our maintenance calendar to ensure regular profession cleaning and removal.

105g - Lint Removal and Duct Cleaning (continued)

Lint trap was cleaned by [REDACTED] SME on 7/28/2022. Notes were placed on 7/28/2022 by [REDACTED] SME. Dryer is to be inspected weekly by SME and was already on the maintenance calendar. Professional cleaning is done twice yearly. Last done by ECOLAB August 2022

Directed:

Per administrator, weekly inspections by SME began 5/7/22.

[REDACTED] 12/1/22

Directed:

Per administrator, former Safety and Maintenance Engineer serviced the dryer on 7/28/2022.

[REDACTED] 12/1/22

Directed Completion Date: 10/04/2022

Implemented [REDACTED] - 04/24/2023)

109b - Rabies Vaccination

9. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 7/26/22, resident #2's miniature poodle was present at the home; however, the home did not have a current certificate of rabies vaccination for this dog.

POC Submission

Directed ([REDACTED] 11/29/2022)

On 8/1/2022 [REDACTED] Life Stages Director obtain the up to date vaccine records for resident #2 miniature poodle. [REDACTED] LSD secured all pet records on 8/1/2022 and compiled them into a binder that she will monitor monthly.

Directed:

Per administrator, monthly monitoring began 8/1/22 and will be ongoing.

[REDACTED] 11/29/22

Directed:

Per administrator, beginning 8/1/22, all new residents and families are asked if a pet will be visiting, and if so, they are directed to provide vaccination records prior to pet's visit.

[REDACTED] 11/29/22

Directed Completion Date: 10/04/2022

Implemented [REDACTED] - 04/24/2023)

132c - Fire Drill Records

10. Requirements

2600.

132c - Fire Drill Records (*continued*)

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

Description of Violation

The fire drill record for the drills conducted on 6/16/22 at 10:15 a.m., 6/22/22 at 1:45 p.m., and 6/30/22 at 6:04 a.m. does not include the number of residents evacuated or the exit routes used during the drills.

POC Submission

Directed () - 11/29/2022)

We are now utilizing the Fire Drill form from the pa.gov website to ensure that all information is gathered and that fire safety prevention is in place.

Date of fire drill form beginning 7/29/2022 by () SME. Fire drill are in SME monitoring system for monthly fire drills this was already in place.

Directed:

Per administrator, SME monthly monitoring in TEL's began 6/28/22.

() 11/29/22

Directed Completion Date: 10/04/2022

Not Implemented () - 04/24/2023)

141a - Medical Evaluation

11. Requirements

2600.

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

Description of Violation

Resident #3 was admitted on ()/21; however, the resident's medical evaluation was not completed until ()/21.

Resident #4 was admitted on ()21; however, the resident's medical evaluation was not completed until ()22.

POC Submission

Accept () - 11/29/2022)

We now have the residence wellness nurse do both assessments pre and post to ensure that there is no time laps moving forward starting on 7/28/2022 This is monitored on a weekly basis by 3 individuals () EOO, () () RWD, () ROD Please note that these dates are prior to the acquisition of the residence by ICC. Weekly monitoring is on going and has been in place since 3/24/2022. () first office date of using this monitoring system was 6/28/2022

Licensee's Plan Completion Date: 10/04/2022

Not Implemented () - 04/24/2023)

141a 1-10 Medical Evaluation Information

12. Requirements

2600.

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation, dated [REDACTED] 22, does not indicate the the resident's height, weight, pulse rate, blood pressure, or temperature.

POC Submission

Directed [REDACTED] - 11/29/2022)

The residence wellness nurse [REDACTED] is now responsible for all admissions and assessments to ensure that nothing is missed on medical evaluation forms moving forward this started on 6/28/2022 Forms are audited on a weekly basis moving forward, audited by [REDACTED] Wellness and Operations Specialist on a weekly basis.

Directed:

Per administrator, resident #1's DME was updated 8/2/22.

[REDACTED] 11/29/22

Directed:

Per administrator, weekly audits began 6/28/22.

[REDACTED] 11/29/22

Directed:

Per administrator, beginning 12/1/22 she will initial all DMEs before a resident is admitted.

[REDACTED] 11/29/22

Directed Completion Date: 10/04/2022

Implemented [REDACTED] - 04/24/2023)

141b1 - Annual Medical Evaluation

13. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's medical evaluation, dated [REDACTED] /21, does not indicate the resident's height, weight, and immunization history.

141b1 - Annual Medical Evaluation (continued)

Resident #5's medical evaluation, dated [REDACTED]/22, does not indicate the resident's temperature. The medical evaluation indicates to see the attached medication list; however, no list is attached.

POC Submission**Accept [REDACTED] - 10/18/2022)**

All resident charts have been audited and brought up to Pa state regulations and ICC policy. Resident #3 chart remains the same as this was pre ownership and have no way to obtain what the vital signs might have been on [REDACTED]/21. We have update immunization history. The medical eval information is now in part of a weekly monitoring system in our computer system and is audited by our RWD and the regions home office nurse.

Weekly monitoring began on 6/28/2022 by [REDACTED]. Weekly chart audits began 5/27/2022 and involved [REDACTED] and [REDACTED] WOD. Resident #5 DME was updated on 8/1/2022. Weekly monitoring began 8/1/2022 by [REDACTED] WOD.

Licensee's Plan Completion Date: 10/04/2022

Implemented [REDACTED] - 04/24/2023)**162c - Menus Posted****14. Requirements**

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 7/26/22 at 11:00 a.m., a menu from 7/1/22 to 7/31/22 was posted on the bulletin board across from the 1st floor main dining room; however, the menu for 8/1/22 to 8/6/22 was not posted.

POC Submission**Accept [REDACTED] 11/29/2022)**

Menus are now posted on a weekly basis to ensure that the current week and the up coming weeks menus are available in the common area outside of the dining room.

Menus posted in two week increments was started 7/28/2022 and updated weekly to provide a look at two weeks of menus, posted by [REDACTED] Dining Events Director. [REDACTED] EOO checks menu posts every Monday morning on [REDACTED] way to 9 am meeting started 7/28/2022

Licensee's Plan Completion Date: [REDACTED]/2022

Implemented [REDACTED] 04/24/2023)**184a - Resident's Meds Labeled****15. 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.

184a - Resident's Meds Labeled (*continued*)

5. The name and title of the prescriber.

Description of Violation

Resident #4 is prescribed 14 units of Tresiba Flex-touch pen 100unit/ml - Inject subcutaneously in the morning. However, on 7/28/22, the pharmacy label was not attached to the medication.

POC Submission

Directed [REDACTED] - 11/29/2022)

Cart audits have been performed and all medications have pharmacy labels. Pharmacy has been notified that if an injectable, eye drop, inhaler must be labeled on the box and the actual medication its self, to ensure that if the original box or container is soiled that the medication can still be safely administered. Staff has been educated that if there is not a label on said medication they are not to administer and notify a supervisor right away. On 7/28/2022 all staff working on medication carts were educated and again in Quarterly meeting on 8/9/2022 ran by [REDACTED] EOO. Carts are monitored weekly on a rotating basis starting on 8/1/2022, and monthly by [REDACTED] WOD

Directed:

Per administrator, on 7/28/22, [REDACTED], RWD, notified the pharmacy as indicated above.

S.Q. 11/29/22

Directed:

Per administrator, weekly monitoring is conducted by [REDACTED] RWD.

S.Q. 11/29/22

Directed Completion Date: 10/04/2022

Implemented [REDACTED] - 04/24/2023)

187d - Follow Prescriber's Orders

16. Requirements

2600.

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

Description of Violation

Resident #1 is prescribed Bacitracin 500 units/gram ointment - Apply topically to bilateral lower extremities affected areas every 3 days. However, from 7/2/22 to 7/26/22, this medication was administered to resident #1 every other day.

POC Submission

Directed [REDACTED] - 11/29/2022)

This has been addressed with pharmacy and staff on 7/28/2022 by [REDACTED] EOO. Staff has been educated that the must read and compare the order in the MAR to the order on the medication bottle or packaging, and not administer until order is clarified by supervisor on 7/28/2022 and in Quarterly meeting on 8/9/2022 ran by [REDACTED] EOO. MAR to Cart audits to be done at least monthly starting on 8/1/2022 and orders are to be review and compared to medication upon new medication deliveries with no exceptions by the lead LPN or MA.

Directed:

Per administrator, beginning 8/1/22, RWD delegates monthly cart audits to the lead LPN or MA.

[REDACTED] 11/29/22

Directed:

Per administrator, beginning 8/1/22, the lead LPN or MA reviews all medication labels from pharmacy to MAR

187d - Follow Prescriber's Orders (continued)

prior to accepting medications with no exceptions.

██████ 11/29/22

Directed Completion Date: 10/04/2022

Implemented (██████ - 04/24/2023)

224a - Preadmission Screen Form**17. 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

There is no preadmission screening form on file for resident #3, who was admitted on ██████/21.

There is not preadmission screening form on file for resident #4, who was admitted on ██████21.

POC Submission

Directed ██████ 11/29/2022)

We acquired the building in March of 2022, we have in place a computer system to ensure that all screening and assessments are done in a timely fashion. The system we utilize allows for reports to be ran to check for missing documentation. This is done weekly by ██████ WOD

Directed:

Per administrator, running of weekly reports began 6/28/22.

██████ 11/29/22

Directed Completion Date: 10/04/2022

Implemented ██████ - 04/24/2023)

225a - Assessment 15 Days**18. 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 #3 was admitted on ██████/21; however, the resident's assessment was not completed until ██████/22.

Resident #4 was admitted on ██████21; however, the resident's assessment was not completed until ██████/22.

POC Submission

Directed ██████ - 11/29/2022)

We acquired the building in March of 2022, we did audit records left by the previous owners in an attempt to locate these assessments without success. This process was started 3/24/2022 and is ongoing originally conducted by ██████ Education Coordinator and now by ██████ on a weekly basis via reports pulled from system. We have in place a computer system and a in person auditing system to ensure that moving forward these assessments are done in a timely fashion. System flags residents when they are due for upcoming assessments and alerts if

225a - Assessment 15 Days (continued)

assessments are over due.

Directed:

Per administrator, the computer system is called MOVE-N, and residents are flagged 7 days prior to assessment due date.

██████ 11/29/22

Directed:

Per administrator, beginning 6/28/22, RWD pulls an assessment report monthly, to review who will be due for an assessment that month.

██████ 11/29/22

Directed Completion Date: 10/04/2022

Implemented (██████ - 04/24/2023)

225c - Additional Assessment**19. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #1's interdisciplinary progress notes and staff interviews indicate resident #1 has increased needs with bladder and bowel management, and has had behavioral changes including tearing mailboxes off the wall, and ████████ another resident's bed and in the hallway. However, resident #1's assessment, dated ██████/22, does not address these changes.

Resident #6 uses a Hoyer lift; however, the resident's assessment, dated ██████/22, does not indicate the need for a Hoyer lift.

POC Submission

Directed (██████ - 11/29/2022)

We updated our charting system to make it easier for increased needs to be charted as well as a new call bell system that tracks resident needs. updated 8/1/2022 to include all LPN's and MA's are in our charting system and understand how and when to chart, this process started on 8/1/2022 and was complete by 8/25/2022. We have insured that all staff is educated on the need for accurate charting to ensure resident well fair and safety on 7/29/2022 and in Quarterly meeting by ████████ EOO and ████████ RWD. Follow up phyc was preformed by LECOM Behavior Health on ██████ 2022 additional Zyprexa ordered. Rasp has been updated by ████████ 8/1/2022.

Resident # 6 record has been updated along with a current script from physical that Hoyer lift is required for all transfers. Hospice would not supply an updated assessment from their doctor. Dr. ████████ to access 10/5/2022

Assessments were added to system that will flag when updates need to be made started 8/1/2022. ████████ RWD educated by ████████ EOO on need to update assessments with all change in condition or need for alternated

225c - Additional Assessment (continued)

interventions on 7/28/2022 and in Quarterly meeting on 8/9/2022 ran by [REDACTED] EOO.

Directed:

Per administrator, resident #6's RASP was updated 8/16/22.

[REDACTED] 11/29/22

Directed Completion Date: 10/04/2022

Implemented ([REDACTED] - 04/24/2023)

227a - Support Plan 30 Days

20. Requirements

2600.

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

Description of Violation

Resident #3 was admitted on [REDACTED]/21; however, the resident's initial support plan was not completed until [REDACTED]/22.

Resident #4 was admitted on [REDACTED]/21; however, the resident's initial support plan was not completed until [REDACTED]/22.

POC Submission

Accept [REDACTED] - 11/29/2022)

We acquired the building in March of 2022, we did audit records left by the previous owners in an attempt to locate these assessments without success. We have in place a computer system and a in person auditing system to ensure that moving forward these assessments are done in a timely fashion. [REDACTED] EC was in charge of auditing charts and this process started on 5/1/2022 and is ongoing now monitored by [REDACTED] weekly.

Computer system generates support plan based on information entered by the RWD [REDACTED] [REDACTED] this process started 6/28/2022 and is ongoing.

Licensee's Plan Completion Date: 10/04/2022

Implemented ([REDACTED] - 04/24/2023)

227g -Support Plan Signatures

21. 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 #1's support plan was completed on [REDACTED] 22; however, was signed by the assessor [REDACTED]/22, and indicates the resident participated and was unable to sign on [REDACTED]/22.

POC Submission

Directed [REDACTED] - 11/29/2022)

This was address with all admissions staff. Moving forward there is a firm plan in place for all assessments in-regards to proper timing and dating of all assessments education given to [REDACTED] RWD on 7/8/2022 and in Quarterly meeting ran by [REDACTED] EOO. This predates myself and [REDACTED] employment as we were hired in May and June.

227g -Support Plan Signatures (continued)

Directed:

Per administrator, the plan includes data entry of the RASP into the computer system the same day the paper assessment is completed, so all dates are aligned.

█ 11/29/22

Directed Completion Date: 10/04/2022

Implemented █ - 04/24/2023)

231e - No Objection Statement

22. 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

Resident #1 was admitted to the SDCU on █ 22; however, the home has no documentation that the resident and the resident's designated person have not objected to the admission.

POC Submission

Directed (█ - 11/29/2022)

Please see attached Memory Care Residency Agreement:

Page 6 section 4.1 also speaks to the secured Memory Care unit.

Pages 14 and 15 number 23 Statement Regarding Scope of Services this speaks to the Memory Care unit being a secure unit.

Page 16 section 24.8 Secured Environment reads:

Resident and Responsible Party and/or Guarantor, if nay, acknowledge that the representative of the Community has antiquated them to the restrictions associated with the secured environment of the Memory Care Program, and that there is no objection to the admission of such, as indicated by signatures below.

Directed:

Per administrator, SDCU resident contracts were updated as of 8/1/22, as indicated above.

█ 11/29/22

Directed:

Per administrator, SDCU resident handbooks also contain resident signature of acknowledgment, and has been in place since 3/1/22.

█ 11/29/22

Directed Completion Date: 10/05/2022

Implemented █ - 04/24/2023)