pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: APRIL 14, 2023

KJ Bethel Park LLC

RE: The Sheridan at Bethel Park
2000 Cool Springs Drive
Pittsburgh, Pennsylvania 15234
License/COC #: 449481

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 1, 2022, August 2, 2022, and August 3, 2022, and December 28, 2022, of the above facility, the violations 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 REVOKES your certificate of compliance (license number 449480) dated May 29, 2022 – May 29, 2023, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST 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) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from April 14, 2023 to October 14, 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.

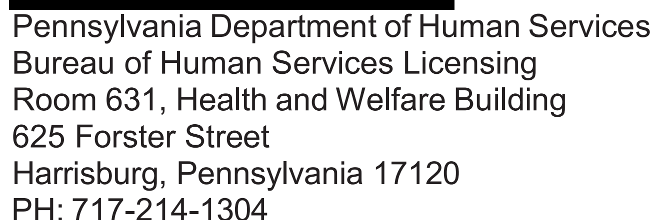
Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

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)
25(b)	II	121	$5	$605	5 calendar days from mailing date of this letter
141(a)	II	121	$5	$605	5 calendar days from mailing date of this letter
184(a)	II	121	$5	$605	5 calendar days from mailing date of this letter
187(d)	II	121	$5	$605	5 calendar days from mailing date of this letter
225(a)	II	121	$5	$605	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:



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

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

Sincerely,

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *THE SHERIDAN AT BETHEL PARK* **License #:** *44948* **License Expiration:** *05/29/2023*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA 15234*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *KJ BETHEL PARK LLC*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA, 15234*

Phone: **Email:**

Certificate(s) of Occupancy

Type: *I 1* **Date:** *12/13/2018* **Issued By:** *Municipality of Bethel Park*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *189* **Waking Staff:** *142*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *08/03/2022*

Inspection Dates and Department Representative

08/01/2022 On Site:
08/02/2022 On Site:
08/03/2022 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* **Residents Served:** *121*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *MC 1 and MC 2* **Capacity:** *40* **Residents Served:** *38*

Hospice

Current Residents: *17*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *120*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *68* **Have Physical Disability:** *1*

Inspections / Reviews

08/01/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/22/2022*

08/26/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/06/2022*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/29/2022*

09/01/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/06/2022*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/06/2022*

01/06/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/06/2022*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

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 8/1/22, at 10:30 a.m., the home's licensing inspection summaries, dated 2/24/21 and 8/24/21, and the current license were not posted in a conspicuous and public place in the home.

POC Submission ***Accept (- 08/26/2022)***

A renewal was sent to the licensing bureau before it expired and we received a notice that due to staffing issues it would take longer than normal to process it. We did receive it on August 12th and we posted it immediately. Unfortunately the email addresses the state had were for the former Executive Director and a corporate person in our licensing department that are no longer with the company so they did not know who to contact.
The new Executive Director and the Regional Director will be responsible going forward to monitor the expiration of the license 90 days prior to expiration of May 2023. We have posted the current inspection in the entrance way of the building in a highly conspicuous place for view. Please see attached photos.
Licensing inspection will be monitored in QA meeting quarterly.

Licensee's Proposed Overall Completion Date: *08/12/2022*

Implemented (- 01/05/2023)

15a - Resident Abuse Report

2. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On or around 7/13/22, direct care staff person A reported an allegation of abuse involving resident #1 to multiple staff, including staff person B; however, the allegation of abuse was not reported to the local Area Agency on Aging.

POC Submission ***Accept (08/26/2022)***

- We began an internal investigation, including consulting our medical director, When the allegations of abuse were unfounded, and the bruising was concluded to be a birth mark and non-consistent with injury or neglect, we were unaware we that still needed to report the incident.
In correction:
- Our ED and our HWD will be responsible for any mandated state reporting in the future, including suspected or unfounded claims of abuse. The state reports will be emailed to the appropriate point of contact and filed in a state reportable binder on site at the facility. The HWD/ED or designee will also report the incident to the Local Agency Aging, resident POA and significant event line per corporate policy. In-service will be held on Abuse reporting, significant event line and riskonnect training and staff will sign off on understanding of education by 9/22/22.
How are we going to monitor going forward:
- Weekly, a high risk resident care meetings will be conducted by the HWD (health and wellness director), HWM (health and wellness manager) or designee with the care team, to talk about any potential situations that would arise with our residents. Weekly meetings will be documented with a flow sheet and placed in the high risk resident documentation binder and kept in the HWD/HWM office. These meeting will start the week of 8/22/22.

15a - Resident Abuse Report (continued)

An in-service will staff will be held by 9/20/22 reviewing the Abuse reporting policy, significant event policy and riskonnect overview training and staff will sign off upon completion of in-service. Trainings will be held annually thereafter and for new staff at orientation upon hire.
Responsible Parties:
- HWD, HWM, and ED in conjunction with the care team, trainings and
At risk meeting minutes will be reviewed at QA meetings quarterly.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented (- 01/06/2023)

15b - Supervisor Plan

3. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On or around 7/13/22, direct care staff person A reported an allegation of abuse involving direct care staff person C to multiple staff, including staff person B; however, staff person C continued to work unsupervised in the home on multiple days and shifts, including 8/3/22 from 7:00 a.m. to 3:00 p.m.

POC Submission ***Accept (- 08/26/2022)***

- When the allegations of abuse were reported HWD/ED but the staff person was not suspended or placed in supervised working conditions. But an investigation was conducted internally following the proper channels.
In correction:
- In the future we will be following the abuse investigation guidelines set forth by our corporate office, in which per line 8 the perpetrator involved must be placed on administrative leave pending the outcome of the investigation.
How are we going to monitor going forward:
- The executive director and the HWD will be responsible for ensuring the proper channels are notified and the employee is placed on administrative leave as soon as the incident is - HWD, ED, divisional director of health and wellness (DDHW) and regional director of operations (RDO) as stated in the guideline attached entitled Abuse Investigations Guideline.

Staff will be in-serviced on appropriate procedures for allegations of abuse and who needs to be notified. Auditing tool for in-service will be completed by 9/22/22. Policy and allegations will be monitored and discussed at quarterly QA meetings.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented (- 01/06/2023)

15d - Resident Abuse-Notification

4. Requirements

2600.

15d - Resident Abuse-Notification *(continued)*

15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

On or around 7/13/22, direct care staff person A reported an allegation of abuse involving resident #1 to multiple staff, including staff person B; however, the home did not report the allegation of abuse to the resident's responsible person.

POC Submission ***Accept ([redacted] 08/26/2022)***

- When the abuse allegations for party #1 were brought to the attention of the administration, we failed to call the residents responsible party as indicated in the policy.
In correction:
- We will immediately place a phone call to the residents responsible party as soon as any mentions of abuse or neglect are suspected. An in-service education on Abuse reporting policy will be reviewed and staff will sign off on understanding by 9/22/22
How are we going to monitor moving forword:
- With the use of our riskonnect audit tool we will ensure the proper parties have been notified of the incident. It is mandatory that all POAs and physicians be notified of all allegations of abuse and be documented in the riskonnect system. We will also re-educate care staff on the use of riskonnect and the appropriate times to do so by 9/22/22 using an education form and staff will sign off on understanding of the appropriate procedure for riskonnect.
Who responsible:
- Reeducation and mandatory abuse reporting will be provided by the HWD/HWM or RCC to the care staff.
- The HWD/ED will monitor the riskconnect audit tool to ensure completion and bring to the attention new incidents with the residents. Incidents in riskonnect will reviewed daily by the HWD and will be investigated promptly if any allegations of abuse are reported using the guidelines in the Abuse reporting policy. HWD will have a daily audit tool for riskonnect monitoring moving forward.
A time frame:
- Riskconnect and abuse reporting training will occur by 9/22/2022 and yearly thereafter with documentation to prove the education occurred in the form of an employee sign in sheet. The riskconnect audit tool will be reviewed by the HWD and ED as they receive alerts of new incidents. Please see our attached education sheet.
Allegations of abuse will be monitored and discussed in QA meetings quarterly.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented ([redacted] - 01/06/2023)

16c - Written Incident Report

5. 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

On or around 7/13/22, direct care staff person A reported an allegation of abuse involving resident #1 to multiple staff, including staff person B; however, the home did not report this incident to the department.

POC Submission ***Accept ([redacted] 08/26/2022)***

Administration did not complete an incident report until Aug 4th. An incident report should have been completed within 24 hours and the state department should have been notified.
An in-service is being held by 9/22/22 on reporting procedures and incident reports and will be discussed in QA

16c - Written Incident Report (continued)

each month for trends. The Health and Wellness Director and Executive Director are the responsible parties. Please see attached in-service sheet.
State reporting binder will be located in HWD/ED office on all state reportable incidents.
An in-service will be held by 9/22/22 reviewing the Abuse reporting policy and the Significant Event policy provided by corporate.

Licensee's Proposed Overall Completion Date: *08/19/2022*

Not Implemented (█ - 01/06/2023)

17 - Record Confidentiality

6. 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 8/1/22, at 11:54 a.m., numerous resident records, including those for residents #2 and #3, were unlocked, unattended, and accessible in the closets in the back hall on the first floor.

POC Submission ***Accept █ - 08/26/2022)***

Why did the incident happen:
- The double door closet which contained closed out records to be sent to offsite storage was locked, however someone forgot to flip the top latch internally to lock it completely, therefore it was able to be pulled open.
In correction:
- The closet will remain locked with both the lock and the latch so no one can access it without a key.
How are we going to Monitor:
- Checking the locks and latches will be done daily on rounding for 4 weeks then 2x weekly thereafter by the supervisor on duty or designee. An Audit tool will be created on all daily rounding tasks to be signed off by responsible party.
Who responsible:
- BOM (Business office Manager), RCC (resident care coordinator (on weekends), DOP (director of plant operations) and HWD (health and wellness director) will create and educate supervisors on duty about daily rounding and distribute copies of the checklist to all responsible supervisors or managers on duty
Monitoring the completion of the audit tool will be reviewed at quarterly QA meetings.
In-service will be held by 9/22/22 to educate staff of appropriate locking up of resident records per HIPAA and attached policy.

Licensee's Proposed Overall Completion Date: *08/18/2022*

Not Implemented (█ 01/05/2023)

23a - Activities of Daily Living Assistance

7. Requirements

2600.

23a - Activities of Daily Living Assistance *(continued)*

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

Description of Violation

Resident #4's most recent assessment and support plan, dated [redacted] indicates the resident requires reminders and staff assistance with bathing and grooming; however, staff interviews indicate the resident has only had one shower in approximately the past 6 weeks, and the resident's hair is severely matted and in knots.

POC Submission ***Directed ([redacted] - 09/01/2022)***

In-service will be done by HWD, HWM, RCC or designee with staff by 9/22/22 Providing care staff with education on positive intention to be used for care of residents resistant to ADLs. In-service on education in documentation for resident refusals and review the Personal care home assistance with ADLs policy will be done by 9/22/22.
Weekly At risk resident meetings will be held with care staff and HWD to recognize and monitored for decline in residents and a need for interventions. At risk residents will be reviewed closely by HWD.

At risk residents meeting minutes will be reviewed at QA meeting.

DIRECTED
Within 15 calendar days of receipt of the accepted plan of correction: The administrator or designated staff person shall provide all direct care staff persons with education on each of the residents assessments and support plans. 9/1/22 JK

Licensee's Proposed Overall Completion Date: 9/22/22

Not Implemented ([redacted] - 01/05/2023)

25b - Contract Signatures

8. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #4's resident-home contract, dated 9/26/19, is not signed by the resident.

Resident #5's resident-home contract, dated 2/21/19, is not signed by the resident.

REPEAT VIOLATION: 2/24/2021 et al.

POC Submission ***Accept ([redacted] - 08/26/2022)***

All contracts have been audited and signed by residents by 9/20/22. The Executive Director signs all contracts with the incoming residents and then the Business Office Manager audits the contracts for signature before submitted to corporate.
10% of all contracts will be audited weekly for 4 weeks starting 8/22/22 through 9/22/22, then monthly thereafter, by the BOM or designee.
Responsible parties: Executive Director, Business Office Manager, Marketing Director. Signed home contracts Auditing tool will be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *08/17/2022*

25b - Contract Signatures *(continued)*

Not Implemented ███ - 01/05/2023)

41e - Signed Statement

9. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Multiple resident records did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures, including residents #4, #5, #6, #7,

POC Submission ***Accept ███ - 08/26/2022)***

Signatures were obtained for residents #4, #5, #6, #7 and a copy of the resident's rights were given to them again.
All contracts will be audited for resident rights signatures acknowledgement, and all residents will be given another copy of the residents rights by 9/22/22. Resident Rights has been also clearly posted in our lobby as of 8/22/22.
10% of all resident right statement signatures will be audited weekly for 4 weeks starting 8/22/22 through 9/22/22 then monthly thereafter by the BOM/ED or designee.
Audit tools for resident rights signatures will be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *08/12/2022*

Not Implemented ███ - 01/05/2023)

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

On 8/1/22, at 10:51 a.m., there were dozens of cigarette butts scattered around the back staff entrance that leads to the kitchen.

POC Submission ***Accept ███ 08/26/2022)***

Area was cleaned by 8/5/22 and signs will be posted for NO smoking by 9/1/22. Please see picture.
Plant operator or designee will monitor daily for 4 weeks starting 8/22/22 through 9/22/22, clean up of cigarette butts and enforce smoking area, then weekly thereafter. Audit tool will be updated for rounding to reflect this area for improvement and compliance by 8/22/22
Smoking area will be audited and signed off by designee and monitored by DPO.
In-service will be held by 9/22/22 for staff reviewing the smoking policy and staff will sign off on understanding of the policy by 9/22/22.
ED will monitor Audit tool during QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented ███ - 01/05/2023)

85e - Trash Outside Home

11. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 8/1/22, at 10:56 a.m., the home's dumpster was open and contained approximately 10 bags of trash. Also, approximately 12 used surgical gloves and 5 plastic utensils were lying on the ground around the dumpster.

POC Submission ***Accept (- 09/01/2022)***

Training will be conducted by the Executive Director or designee on regulation 2600.85.e. to dining, housekeeping, maintenance and care staff by 9/22/22.
The dumpster area is to be monitored daily by the housekeeping and maintenance staff beginning 8/29/22. The daily audit will be reviewed weekly by the Director of plant Operations. Documentation will be maintain on site. Compliance will be reviewed in QA meetings.

Licensee's Plan Completion Date: *09/22/2022*

Implemented (- 01/05/2023)

91 - Telephone Numbers

12. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 8/1/22, there were no emergency telephone numbers, to include the nearest hospital and fire department, on or by multiple telephones, including:

- *The phone in resident bedroom*
- *The phone in MC2's sitting room*
- *The phone located in the hallway behind the conference room*

POC Submission ***Accept (- 08/26/2022)***

We immediately corrected and attached phone numbers to the phones while the surveyor was still in the building. All phones with outgoing lines were audited for the appropriate emergency phone numbers weekly for 4 weeks then monthly thereafter using an audit tool created. This task was given to DOP, housekeeping or designee and be done weekly until 9/22/22. We laminated extra tags to keep on hand if one were to go missing. In-service held by 9/22/22 educating staff on requirement to have emergency phone numbers at all outgoing phone lines in community, Staff will sign off on in-service record understanding education.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Implemented (- 01/05/2023)

101j7 - Lighting/Operable Lamp

13. 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.

101j7 - Lighting/Operable Lamp *(continued)*

Description of Violation

On 8/2/22, at 11:30 a.m., resident #6 did not have access to a source of light that can be turned on/off at bedside. The lamp was located on a dresser approximately 6' away from the resident's bed.

POC Submission ***Accept - 08/26/2022)***

The resident's had moved the nightstand by bedside into the living room to place puzzle books near while watched tv. We place another night stand in the room and moved the lamp onto that table within arm's reach of the bed.
Audit tool created for DOP or designee to check all resident room for lamps in working condition placed within 6' from bed weekly for 4 weeks until 9/22/22 then monthly there after. In-service held by 9/22/22 to educate staff on this state mandated policy for working lamps to be accessible to residents within 6' from residents bed. Staff will sign off of understanding or education on the in-service training record by 9/22/22.
Audit tool to be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Implemented - 01/05/2023)

103e - Left Overs

14. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 8/1/22, at 11:18 a.m., there was an undated box containing 3 pieces of pizza in the MC2 refrigerator.

POC Submission ***Accept - 08/26/2022)***

There were 2 pieces of pizza in a box that was left in a fridge by the resident in memory care from the night before. The staff did not date food when it was placed in refrigerator.
Incorrection we will hold an in-service for staff to educated on the food storage policy per corporate and state regulations, staff will sign off on understanding by 9/22/22.
Staff was educated and an audit tool developed to audit each refrigerator daily. Daily Audit will be done by the Dining services Director or designee daily and signed off on the audit tool. Please see attached tool.
Responsible parties are Dining services director or designee and Executive Director
Audit tool for food storage will be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented 01/05/2023)

103f - Refrigerator/Freezer Temps

15. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 8/1/22, at 10:44 a.m., there was no thermometer in the ice cream freezer in the main kitchen.

103f - Refrigerator/Freezer Temps *(continued)*

POC Submission ***Accept ███- 08/26/2022)***

The thermometer in the ice cream was missing and unseen by surveyor. Later in between meals DDS was asked where the thermometer was and he located it underneath one of the containers not between them which would have been visible to the E.D. and the surveyor.
Refrigerator temp log audit tool created to track all thermometers and temps in all refrigerators in kitchen area. Log will be signed and dated by DDS or designee daily.
In-service held for staff to review refrigerator temp log and food storage temperature policy, staff will sign in-service training to acknowledge understanding by 9/22/22.
Refrigerator temp log audit tool to be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *08/15/2022*

Not Implemented ███- 01/05/2023)

103i - Outdated Food

16. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 8/1/22, at 10:49 a.m., there was a dented 114 oz. can of Heinz ketchup on the shelf in the food storage room.

POC Submission ***Accept ███- 09/01/2022)***

The dented 114 oz can of Heinz ketchup was removed from the shelf and disposed of. In-service training will be provided to staff regarding food storage policy, adding emphasis to the line stating, "Canned food items that have significant defects such as swelling or leakage shall not be used. Food that is adulterated, contaminated or otherwise unfit for human consumption shall not be served." Training to be completed by the Executive director or ███ designee by 9/22/22.
DDS (Director of dining services) or designee will audit every food shipment to ensure that all food is safe for human consumption. If any food is damaged it will be discarded immediately. ED will monitor food audit form monthly to ensure compliance beginning in September.
Food storage/ audit form will be reviewed in QA meeting.

Licensee's Plan Completion Date: *09/22/2022*

Not Implemented ███- 01/05/2023)

107a - Emergency Preparedness

17. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

Staff person D, the home's administrator does not have the emergency preparedness plan for the local municipality.

POC Submission ***Accept ███- 09/01/2022)***

The emergency preparedness binder has been updated to include the emergency preparedness plan for the local municipality. Please see photos.
Training will be provided to all staff educating them on the location of the emergency preparedness binder and

107a - Emergency Preparedness (continued)

what information is stored inside, including but not limited to the local municipality emergency numbers and preparedness plan by the Executive Director or his/hers designee.
New staff will be educated on the emergency preparedness binder, its contents and location, in orientation from here on and policy will be reviewed.
Emergency Preparedness binder compliance will be monitored by the Executive Director or his/her designee monthly for 3 months beginning in September 2022.

Licensee's Plan Completion Date: *09/22/2022*

Not Implemented (- 01/05/2023)

107c - Food/Water 3 Day Supply

18. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 8/1/22, the home served 120 residents, requiring 360 gallons of emergency drinking water. However, the home had no emergency water supply, and the home does not have a contract with a local bottled water supplier.

POC Submission ***Directed 9/01/2022)***

360 gallons of emergency water was delivered to the home on 8/19/22. Sales receipt attached. The home has procured an emergency water supplier to provide emergency water in case of an emergency. The emergency water supplier letter is attached. The DDS (Dining Services Director), DPO (Director of plant operation) or designee will be responsible for doing a monthly audit to monitor emergency water supply to ensure compliance beginning in September 2022. Training will be provided to staff regarding the state regulation to have a 3 day supply of drinking water for every resident by the Executive Director or his/her designee. Compliance will be reviewed in QA meeting.

DIRECTED
Within 15 calendar days of receipt of the accepted plan of correction: The administrator or designated staff person will audit the home's emergency water to ensure compliance with Regulation 2600.107(c). 9/1/22

Directed Completion Date: *09/22/2022*

Not Implemented 01/05/2023)

124 - Notice to Fire Department

19. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency. The home serves 68 residents with mobility needs.

POC Submission ***Accept - 08/26/2022)***

Please see the letter attached to the Fire Department with the address, floor plan and the type of assistance needed

124 - Notice to Fire Department (continued)

to evacuate in an emergency.
ED and DPO will maintain updating fire Department monthly as our census in the community changes.
In-service will be held for staff reviewing our Fire Drill policy and state regulations for local fire department to be educated on our resident census for evacuation and fire safety, staff will sign off to acknowledge understanding of education by 9/22/22.
Letter to local fire department with evacuation needs will be reviewed in QA meetings.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Implemented [redacted] 01/05/2023)

132a - Monthly Fire Drill

20. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the months of December 2021, and January 2022 through May 2022.

POC Submission ***Accept [redacted] - 08/26/2022)***

There was an unannounced fire drill held in December 2021. Each month an unannounced fire drill will be held. This regulation was reviewed and education was held with Physical plant team and Health and Wellness team, Monthly compliance will be reviewed by ED and DPO.
Please see copy of December fire drill and signed education statement form team acknowledging and will be discussed at monthly manager's meeting and QA meeting.
Please see Monthly audit sheet for compliance with the state regulation on fire drills. DPO and designees will maintain monthly compliance moving forward.
In-service will be held by DPO, HWD or designees for staff reviewing our Fire Drill policy and staff will sign off to acknowledge understanding of education by 9/22/22.
Monthly fire drill compliance will be reviewed in QA meetings.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Implemented [redacted] - 01/05/2023)

132b - Safety Inspection/Fire Drill

21. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and drill observed by a fire safety expert was conducted on 12/10/19.

POC Submission ***Accept [redacted] - 08/26/2022)***

A fire Safety expert is scheduled to complete an inspection and survey on August 30 2022.
Compliance with annual Fire safety expert inspection will be done by the DPO and overseen by the ED of the community.
Fire safety inspection will be reviewed in QA meeting.

132b - Safety Inspection/Fire Drill *(continued)*

Licensee's Proposed Overall Completion Date: *08/30/2022*

Implemented - 01/05/2023)

132d - Evacuation

22. 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 does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

- *6/21/22 at 1:30 p.m., evacuation time of 6 minutes 50 seconds*
- *7/19/22 at 4:00 p.m., evacuation time of 6 minutes 47 seconds*

POC Submission ***Directed - 09/01/2022)***

A fire safety expert is scheduled to be onsite August 30 2022 to conduct a safe fire evacuation analysis and provide in writing the a maximum amount time the residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire safe area. The Executive Director or designee will train the maintenance staff and on the regulation 2600.132.d. The Executive Director or designee will monitor the fire drills monthly for evacuation times being in September 2022.
Fire drill compliance and evacuation times will be reviewed in QA meeting.

DIRECTED
Within 15 calendar days of receipt of the accepted plan of correction: If the home is unable to meet the safe evacuation time specified by the fire safety expert the home shall conduct at least two fire drills a month until the home can meet the safe evacuation time specified in writing by a fire safety expert within the past year, for three consecutive months. If the home still exceeds the safe evacuation time specified in writing by a fire safety expert within the past year, the home will add additional staff to the regular schedule and maintain that staffing level at all times, to ensure residents are evacuated within the time specified by the fire safety expert. 9/1/22

Licensee's Proposed Overall Completion Date: 9/30/22

Not Implemented 01/05/2023)

132e - Fire Drill Sleeping Hours

23. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

There has been no fire drill held during sleeping hours in the past 6 months.

POC Submission ***Accept 08/26/2022)***

An overnight fire drill was held on August 18, 2022 at 5:50am during overnight shift. Please see attached.
Director of Plant operations (DPO) or designee educated staff on overnight fire drill requirements per state

132e - Fire Drill Sleeping Hours (continued)

regulations and a log was created to keep track of drills.
Audit log for tracking overnight fire drills will be maintained by DPO or designee and overseen by ED of community.
In-service will be held by DPO, HWD or designee for staff to review the Fire drill policy and fire drill time expectations and overnight fire drills. Staff will then sign off on understanding of Fire drill procedure and compliance by 9/22/22.
Overnight Fire drill compliance and evacuation times will be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Implemented █ - 01/05/2023)

141a - Medical Evaluation

24. 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 #6's initial medical evaluation, dated 5/26/22, did not include the resident's height and weight. These areas of the form are blank.

A medical evaluation was not completed for resident #9, admitted to the home on 3/1/21.

REPEAT VIOLATION: 2/24/2021 et al.

POC Submission ***Accept █ - 08/26/2022)***

Initial medical resident evaluation did not include residents height and weight and Resident #9 DME was not located in chart.
The community will now have an audit tool being overseen by 2 people for each initial medical resident evaluation to ensure completeness and correctness.
Starting will the Director of marketing during the preadmission process then by the HWD/HWM or RCC during the admission process. An excel sheet will be updated as the new DME are produced to keep track of expiration dates for medical resident evaluations.
The Director of Marketing will ensure that all parts of the DME will be filled out prior to admission, then The HWD, HWM or designee will review the medical evaluation upon admission of each new resident and upon yearly renewal of these evaluations.
Responsible party: Director of Marketing, HWD & HWM
Time frame:
- The new DMEs were updated and signed by the medical director as of the week of 8/2/2022. The new process of double checking will begin upon each new move in going forward.
10% of all DME in charts will be audited weekly starting 8/15/22 to ensure compliance with DMEs and then monthly thereafter.
DME compliance will be reviewed at QA meeting.

Licensee's Proposed Overall Completion Date: *08/26/2022*

Not Implemented █ - 01/05/2023)

141b1 - Annual Medical Evaluation

25. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #4's most recent medical evaluation was completed on

Resident #5's most recent medical evaluation was completed on

Resident #7's most recent medical evaluation was completed on

Resident #8's most recent medical evaluation was completed on

Resident #10's most recent medical evaluation was completed on

Resident #12's most recent medical evaluation was completed on

POC Submission ***Accept - 08/26/2022)***

All resident's DME's were updated and signed by the PCP 8/22/22 and entered into their charts. An audit tool will be part of the chart as well and completed by the Health and Wellness Director and Health and Wellness Manager. Annual medical evaluations will be monitored with an audit tool created to maintain all dates of when DMEs were updated last. Chart audit tool was created to audit charts monthly.
Moving forward, DMEs with dates will be added to the audit tool upon admission. DME's will be updated annually based on the dates in the audit tool.
10% of charts will be audited for DME compliance starting 8/15/22 and will continue weekly for 4 weeks. Charts will be audited for compliance by HWM or designee monthly thereafter for document compliance. Audit tool compliance and documentation will be overseen by HWD and ED.
DME compliance and audit tool use will be reviewed in QA meetings.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented - 01/05/2023)

162c - Menus Posted

26. 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

The menu posted in the home ended on 8/6/22.

POC Submission ***Accept (09/01/2022)***

Menus were posted to comply with regulation on 8/06/2022. The Executive Director or his/her designee will train the appropriate staff on regulation 2600.162.c. Weekly audits will be completed by the Dining Services Director or designee being the week of 8/29/22. The Executive Director or designee will monitor the weekly reports monthly for 3 months being in September 2022 for compliance. Menu compliance will be reviewed at the QA meeting.

Licensee's Plan Completion Date: *09/22/2022*

162c - Menus Posted *(continued)*

Implemented ███ 01/05/2023)

183b - Meds and Syringes Locked

27. 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 8/2/22, at 11:30 a.m., there was an unlocked and accessible tube of diclofenac sodium topical gel in a basket on resident #6's bedside table.

On 8/2/22, at 12:13 p.m., there was a bottle of Nyamyc nystatin powder unlocked, unattended, and accessible on resident #5's bathroom counter.

On 8/3/22, at 2:47 p.m., there were multiple medications unlocked and accessible on the end table in resident #16's sitting area, including:

- *Ofev (nintedanib capsules) 150mg*
- *Tylenol and vitamins, in a weekly pill pack*
- *azelastine hydrochloride and fluticasone propionate nasal spray*
- *Symbicort inhaler*

POC Submission ***Accept ███ - 09/01/2022)***

Utilizing the MAR to cart audit sheets will be used to monitor any medications left in residents room that are not locked up. Med Tech will have to sign off that he/she did a walking round of rooms daily and found no medication in the room. Mar to cart audits will be done daily for 4 weeks then weekly starting 8/22/22. Mar to cart audits will be reviewed by HWD.
Self Medicating residents will be reeducated on locking up all medications in rooms by 9/22/22 by the HWD.
In-service will be provided to staff by the HWD,HWM, RCC or designee to review that resident self medication and storage policy by 9/22/22. Staff will sign acknowledgement and understanding of policy.
MAR to cart audit tool will be reviewed in QA meeting.

Licensee's Plan Completion Date: *09/22/2022*

Not Implemented ███ 01/05/2023)

183d - Prescription Current

28. Requirements

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

Description of Violation

On 8/2/22, resident #6's jar of polyethylene glycol was in the home's medication cart; however, the medication was discontinued on 6/23/22.

POC Submission ***Accept ███ - 09/01/2022)***

Utilizing a MAR to cart audit tool we can ensure that the only medications in the medication carts match the

183d - Prescription Current (continued)

medications in the MAR for each resident.
MAR to cart audit tools will be done daily for 4 weeks and then weekly starting 8/22/22 and reviewed daily by HWD.
When a medication is discontinued the med tech will be responsible for removing the medications from the cart that day per MD order.
An outside nurse will conduct audits quarterly from our local pharmacy, Symbria. Next cart audit done by Symbria will be in October.
MAR to cart audit compliance will be reviewed in QA meetings.

Licensee's Plan Completion Date: *09/22/2022*

Implemented (█ - 01/05/2023)

184a - Resident's Meds Labeled

29. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #6 is prescribed the following medications:

- *Acetaminophen 160mg/5ml liq-take 20ml by mouth every 6 hours as needed for pain; however, the pharmacy labels indicate-take 20ml by mouth twice a day for pain, and take every morning and every 6 hours as needed for pain.*
- *Bisacodyl 10mg suppository-insert 1 suppository rectally once daily as needed; however, the pharmacy label indicates-insert rectally every 3rd day for constipation*

REPEAT VIOLATION: 2/24/2021 et al.

POC Submission ***Accept (█ - 08/26/2022)***

Resident #6 labeling has been change to reflect to reflect the MAR with,
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber
on the MAR.
The order was changed but we failed to relabel the medication.
In correction:
A change of direction sticker from the pharmacy will be placed on any medication that is the same dose and different directions.
How will we monitor going forward:
HWM, RCC or designee will oversee MAR to cart audits daily for 4 weeks and then weekly thereafter. Med techs

184a - Resident's Meds Labeled (continued)

will also report changes by MD to HWD or HWM immediately and apply a "change in directions, see MAR" sticker immediately.
In the future we will be utilizing a MAR to cart audit tools to ensure that the only medications in the medication carts match the medications in the MAR for each resident. An outside nurse will conduct audits quarterly from our local pharmacy. MAR to cart audits will be done daily for 4 weeks and then weekly thereafter.
How are we going to monitor moving forward:
- MAR to Cart audits will be done by the med techs and be overseen for compliance by our HWD/HWM/RCC or designee.
In-service will be done by 9/22/22 for all med techs and nurses to educate on new MAR to Cart audit tool to be done daily for 4 weeks and then weekly thereafter. Staff will sign off acknowledging the education and understanding by 9/22/22.
MAR to cart audit compliance will be reviewed in QA meetings.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented 01/05/2023)

187d - Follow Prescriber's Orders

30. Requirements

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

Description of Violation

Resident #6 is prescribed morphine sulfate 100mg/5ml solution-Take 0.25ml by mouth twice daily; however, the medication was not administered on 7/31/22 at 3:00 p.m., 8/1/22 at 7:00 a.m. and 3:00 p.m., and 8/2/22 at 7:00 a.m. because it was not available in the home.

Resident #12 is prescribed Pro-Apply topically to twice a day; however, the medication was not administered from 7/1/22 through 8/2/22.

Resident #14 is prescribed warfarin sodium 2.5mg tab –Take 1 tablet by mouth once daily; however, the resident was administered warfarin sodium 4mg tablet daily from 7/17/22 through 8/1/22.

REPEAT VIOLATION: 8/24/2021

POC Submission ***Accept 09/01/2022)***

In-service will be done by 8/22/22 for all med techs and nurses to educate on new MAR to Cart audit tool to be done daily for 4 weeks and then weekly. MAR to cart audits will be reviewed by HWD daily for compliance. Med variance reports will be printed by Med techs every shift starting 8/22/22 and reviewed by the HWD daily for compliance.
In-service will review appropriate documentation process for resident medications changes or medication refusal of medications and who was notified per the corporate documentation policy guidelines by 9/22/22.
Staff will sign off acknowledging the education and understanding by 9/22/22. Using the MAR to cart audit tool weekly will correct any order changes in MAR, dose changes in MAR and documentation of medication refused.
MAR to cart audit compliance will be reviewed in QA meetings.

Licensee's Plan Completion Date: *09/22/2022*

187d - Follow Prescriber's Orders *(continued)*

Not Implemented - 01/05/2023)

191 - Resident Right to Refuse

31. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Multiple residents have not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error, including:

- *Resident #4, admitted*
- *Resident #5, admitted*
- *Resident #6, admitted*
- *Resident #7, admitted*
- *Resident #8, admitted*

POC Submission ***Accept (- 08/26/2022)***

All residents were given another copy of the residents rights which states they have the right to refuse medication. Another signed copy will be put in their files.
10% of resident files will be audited weekly by the BOM or designee to document compliance of resident rights signatures for 4 weeks then monthly and upon admission thereafter.
In-service will be done for staff to review resident rights to refuse medications by 9/22/22 and staff will acknowledge understanding.
Resident rights education will be audited by the BOM or designee and overseen by the ED.
Resident rights to refuse medications will be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented 01/05/2023)

201 - Positive Interventions

32. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Staff interviews indicate resident #4 has refused showers on a regular basis and has only had one shower in approximately the past 6 weeks; however, the home has not implemented positive interventions to modify or eliminate the behavior.

POC Submission ***Directed 09/01/2022)***

In-service will be done by HWD, HWM, RCC or designee with staff by 9/22/22 Providing care staff with education on positive intention to be used for care of residents resistant to ADLs. In-service on education in documentation for resident refusals and review the Personal care home assistance with ADLs policy will be done by 9/22/22.

201 - Positive Interventions (continued)

Weekly At risk resident meetings will be held with care staff and HWD to recognize and monitored for decline in residents and a need for interventions. At risk residents will be reviewed closely by HWD.
At risk residents meeting minutes will be reviewed at QA meeting.

DIRECTED
Within 15 calendar days of receipt of the accepted plan of correction: The home shall document all positive interventions used in the residents assessment and support plan, 9/1/22

Within 15 calendar days of receipt of the accepted plan of correction: The administrator or designated staff person shall provide all direct care staff persons with education on each of the residents assessments and support plans. 9/1/22

Licensee's Proposed Overall Completion Date: 9/22/22 ***Not Implemented (01/05/2023)***

224a - Preadmission Screen Form

33. 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

Resident #6 was admitted to the home on however, no preadmission screening was completed.

Resident #7 was admitted to the home on however, no preadmission screening was completed.

Resident #9's preadmission screening, dated 2/23/21, does not include the resident's level of supervision needed or the home's ability to meet the resident's needs. These sections of the form are blank.

Resident #13's preadmission screening does not include the resident's date of birth or the home's ability to meet the resident's needs. These sections of the form are blank. Also, the form is undated; therefore, it is unable to be determined if it was completed in a timely manner.

Resident #14 was admitted to the home on however, no preadmission screening was completed.

Resident #15 was admitted to the home on , however, the preadmission screening is undated. Therefore, it is unable to be determined if it was completed in a timely manner.

POC Submission ***Accept (- 08/26/2022)***

Resident #6 prescreen as located and placed in chart. Resident #7 Prescreen was located and placed in chart. Resident # 9 was updated with the level of supervision needed to meet the needs of the resident. Resident #13 DOB was added to the prescreen and the home ability to take care to the resident was added. Resident #14 prescreen was located and added to the chart. Resident #15 was dated appropriately and added to the chart.
For multiple residents the preadmission screen was not dated corrected, no birthdate or not present in the chart at all.
To correct this now all charts have been audited with our audit tool for any missing preadmission screens, missing

224a - Preadmission Screen Form (continued)

dates or DOB.
10% of all charts will be audited by the HWM, RCC or designee weekly for corrected Prescreen and then monthly thereafter to maintain compliance with correct documentation for charts.
In the future we plan to use this audit tool monthly on the charts to ensure chart and documentation compliance.
Our HWD (Health and Wellness Director) and HWM will also be in charge of completing and filing all future preadmission screening tools with correct dates and filing in charts.
Health and wellness director is responsible for preadmission screens on new admissions and Health and wellness manager is responsible for overseeing quarterly charge audits.
Chart audit forms will be reviewed at QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented ███- 01/05/2023)

225a - Assessment 15 Days

34. 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 #6 was admitted on ███ however, the resident's initial assessment was not completed until 7/1/22 and does not include an assessment of the residents' needs for:

- *securing and managing healthcare*
- *turning and positioning in bed/chair*
- *using the telephone*
- *making and keeping appointments*
- *caring for personal possessions*
- *writing correspondence*
- *obtaining clean, seasonal clothing*
- *irritability*
- *agitation*
- *aggression*
- *ability to use and avoid poisonous material*
- *the diagnoses of cerebral atherosclerosis, vascular dementia with behavior, history of TIA, stroke, hypertension, and hyperlipidemia as indicated on the resident's physician orders, dated 8/2/22*

Resident #15 was admitted on ███ however, the resident's initial assessment was not completed until 3/11/22 and does not include an assessment of the residents' needs for:

- *securing and managing healthcare*
- *turning and positioning in bed/chair*
- *using the telephone*
- *making and keeping appointments*
- *caring for personal possessions*
- *writing correspondence*
- *obtaining clean, seasonal clothing*
- *irritability*

225a - Assessment 15 Days (continued)

- *agitation*
- *aggression*
- *ability to use and avoid poisonous material*

REPEAT VIOLATION: 8/24/2021

POC Submission ***Accept (█ - 08/26/2022)***

A new RASP will be created to address these resident's needs by August 22nd and an audit tool was developed to monitor the appropriate date i.e. yearly, change of condition.
We have recently just converted all of our written assessments into an electronic system called Yardi. We are continuing to educated staff of the use of this new Yardi system. All of our assessment in the future will be monitored and printed from this system.
All assessments and support plans will be reviewed and audited by the Health and Wellness director (HWD), Health and Wellness manager (HWM) and the Resident care coordinator (RCC).
10% of All assessments and support plans will be audited for compliance weekly for 4 weeks then monthly thereafter, in all areas that resident needs support such as securing and managing healthcare, turning and positioning in bed/chair, using the telephone, making and keeping appointments, caring for personal possessions, writing correspondence, obtaining clean, seasonal clothing, irritability, agitation, aggression, ability to use and avoid poisonous material, but not limited to these areas.
In the future we will be printing a report from Yardi at the beginning of the each week listing all of upcoming resident assessment due. This will prevent us from falling behind in entering the assessment into the computer system. In the future previous assessments charted can me pulled from computer systems with dates within for compliance.
RASP compliance will be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented █ - 01/05/2023)

225c - Additional Assessment

35. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

The following residents had their assessments completed on the following dates; however their previous assessments were not located, therefore it is unable to be determined if their most recent assessment was completed timely:

- *resident #5, 3/8/22*
- *resident #7, 9/3/22*
- *resident #8, 2/21/22*
- *resident #9, 3/22/22*
- *resident #11, 2/27/22*
- *resident #12, 4/18/22*
- *resident #13, 3/17/22*
- *resident #14, 9/8/21*

225c - Additional Assessment (continued)

Also, their assessment does not include an assessment of the residents' needs for:

- *securing and managing healthcare*
- *turning and positioning in bed/chair*
- *using the telephone*
- *making and keeping appointments*
- *caring for personal possessions*
- *writing correspondence*
- *obtaining clean, seasonal clothing*
- *irritability*
- *agitation*
- *aggression*
- *ability to use and avoid poisonous material*

Resident #10's most recent assessment and support plan was completed on 5/17/22; however, the resident's previous assessment was completed on 4/30/21.

POC Submission ***Accept ██ 09/01/2022)***

A new Support plan was created to address these resident's needs by August 22nd and an audit tool was developed to monitor the appropriate date i.e. yearly, change of condition.
We have recently just converted all of our written assessments into an electronic system called Yardi. We are continuing to educated staff of the use of this new Yardi system. All of our assessment in the future will be monitored and printed from this system.
All assessments and support plans will be reviewed and audited by the Health and Wellness director (HWD), Health and Wellness manager (HWM) and the Resident care coordinator (RCC).
10% of All assessments and support plans will be audited for compliance weekly for 4 weeks then monthly thereafter, in all areas that resident needs support such as securing and managing healthcare, turning and positioning in bed/chair, using the telephone, making and keeping appointments, caring for personal possessions, writing correspondence, obtaining clean, seasonal clothing, irritability, agitation, aggression, ability to use and avoid poisonous material, but not limited to these areas.
In the future we will be printing a report from Yardi at the beginning of the each week listing all of upcoming resident assessment due. This will prevent us from falling behind in entering the assessment into the computer system. In the future previous assessments charted can me pulled from computer systems with dates within for compliance.
Support plan compliance will be reviewed in QA meeting.

Licensee's Plan Completion Date: *09/29/2022*

Not Implemented ██ - 01/05/2023)

227a - Support Plan 30 Days

36. 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.

227a - Support Plan 30 Days *(continued)*

Description of Violation

Resident #6 was admitted on [redacted] however, the resident's initial support plan was not completed until 7/1/22.

POC Submission ***Accept ([redacted] - 08/26/2022)***

Resident #6 support plan was updated and filed in chart.
All residents will have a support plan developed within 30 days of their admission pursuant 227.a.
10% of the charts will be audited weekly, for 4 weeks then monthly thereafter to monitor dates on RASPs. .
A report will be generated weekly from our Yardi system and all resident support plan will be completed within 30 days of admission. The report will be kept in a binder when all current residents and newly admitted residents have RASPs completed.
The chart audits will monitored and tracked by the HWM, RCC or designee.
Weekly Yardi reports will be generated and monitored by HWD.
Compliance with RASPs documentation will be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented ([redacted] - 01/05/2023)

227c - Support Plan Revision

37. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #4's most recent support plan, dated 3/9/22, indicates the resident has no problems with judgment, does not resist care, and makes appropriate decisions; however, staff interviews indicate the resident regularly refuses a shower and [redacted] medications and has only had one shower in approximately the past 6 weeks.

Resident #6's most recent support plan, dated 7/1/22, indicates [redacted] receives hospice care but does not indicate what specific services they are responsible for providing.

Resident #9's most recent support plan, dated 3/22/22, indicates the resident does not require 2-person assistance with transfers and does not use transferring enabling devices and methods; however, the resident is a 2-person assist for transfers and uses a halo safety ring to transfer out of bed.

POC Submission ***Accept ([redacted] - 09/01/2022)***

Resident #4, Resident #6 and Resident #9 Support plans were updated to reflect their ADL needs.
Weekly have At risk resident meeting, Support plans will then be updated based on the At Risk meeting results and resident ADL needs. . A record of all at risk resident will be tracked in a binder for all Support plans to be updated within 30 days of significant changes.
The Health and wellness manager (HWM), RCC or designee will conduct the meetings with the oversight of the Health and Wellness director. The meeting minutes will be kept in a binder. All Support plans will be updated by the HWD and/or HWM based on the meeting details. Meetings will be held weekly starting 8/22/22.
At risk resident meeting minutes will be reviewed in QA meeting.

Licensee's Plan Completion Date: *08/29/2022*

Not Implemented ([redacted] - 01/05/2023)

227g -Support Plan Signatures

38. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Numerous support plans were not signed by the assessor or by the resident, including:

- *resident #4's support plan, dated 3/9/22*
- *resident #7's support plan, dated 9/3/22*
- *resident #9's support plan, dated 3/22/22*
- *resident #10's support plan, dated 5/17/22*

POC Submission ***Accept [redacted] - 08/26/2022)***

Resident #4, Resident #7, resident #9, and resident # 10 support plans have been dated and signed by resident and responsible party and placed in chart.
While the work on getting all of our support plans into our electronic system they did not get signed by residents.
10% of all charts will be audited weekly starting 8/15/22, for 4 weeks, for signatures and dates for all residents, then monthly thereafter. A log has been created of all residents and the date the RASP was completed and signed. Annual care conferences will be scheduled for all residents and POAs to review Support plan and to be signed by all parties.
Log for care conferences will be created and used to schedule annual meetings.
All audits will be done by HWD, RCC or designee and monitored by the HWD.
Compliance with chart audits and RASP compliance will be reviewed at QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented [redacted] 01/05/2023)

231b - Medical Evaluation

39. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #15 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] however, the resident's medical evaluation, dated 1/28/22, does not indicate a diagnosis of Alzheimer's disease or dementia or the need for the resident to be served in a SDCU.

POC Submission ***Accept [redacted] 08/26/2022)***

Resident #15 DME was updated by a physician and placed in chart.
Resident #15 did not have an updated DME indicating his new diagnosis of dementia to be admitted to SDCU.
HWD, HWM and memory care director will monitor all DMEs on admission and annually to ensure all residents in SDCU have an active dementia or Alzheimer's diagnosis.
10% of all charts in memory care will be audited weekly starting 8/15/22 for 4 weeks then monthly thereafter. All chart audits will have the correct DME date and diagnosis of Dementia or Alzheimer's. All chart audits will be done by HWM, RCC or designee and monitored for compliance by HWD.
DME compliance will be reviewed in QA meeting.

231b - Medical Evaluation *(continued)*

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented (- 01/05/2023)

231c - Preadmission Screening

40. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #14 was admitted to the SDCU on However, a written cognitive preadmission screening was not completed until 8/4/22, and the need for the resident to reside in a SDCU due to Alzheimer's or dementia is not indicated.

Resident #15 was admitted to the SDCU on However, a written cognitive preadmission screening was not completed.

POC Submission ***Accept (- 08/26/2022)***

Resident #14 prescreen was completed and filed in chart, diagnosis of Dementia was added to DME, signed by physician and added to the chart.
Resident #15 written cognitive prescreen was written and added to the chart.
The resident noted above did not have a new preadmission screen done after his need to be admitted to the SDCU. The resident was in the personal care home community when he was found wandering out into the parking lot in his wheelchair. The resident was assessed by the memory care director and was admitted into the SDCU. When resident #15 was admitted from personal care to SDCU a new preadmission screen was not completed and filed in chart.
In the future any resident who needs admitted to the SDCU from the personal care community will have a new preadmission screen done with a new assessment from an admitting MD with a dementia diagnosis. A new RASP will be created reflecting the new admission to SDCU. All will be done within 72 hours of admission to SDCU.
The HWD and memory care director will monitor all preadmission screen, DME's and RASPs for all SDCU residents. This will be done with his initial assessment prior to transfer and filed in the chart.
10% charts in memory care will be audited for good preadmission screens and dates, weekly for 4 weeks then monthly after starting 8/15/22 through 9/22/22.
HWD, MCD and/or HWM will be responsible for monitor audits and correcting noncompliance.
Preadmission screen compliance will reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented (- 01/05/2023)

231e - No Objection Statement

41. 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 #14 was admitted to the SDCU on however, the home has no documentation that the resident and

231e - No Objection Statement (continued)

the resident's designated person have not objected to the admission.

POC Submission ***Accept ███ 08/26/2022)***

A memory care addendum was signed by resident on August 16th and placed in his file. All memory care resident's charts were audited for no objection or memory care addendum.
Responsible parties: Executive Director, Memory Care Director, and Business Office Manager
Changes to resident records will be reviewed at QA meeting.

Licensee's Proposed Overall Completion Date: *08/16/2022*

Implemented ███ 01/05/2023)

233a - Lock Approval

42. Requirements

2600.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the locking device, used on the exit doors from the SDCU.

POC Submission ***Accept (███ - 08/26/2022)***

Please see the letter of Lock approval.
In the future the DPO with the ED of community will oversee the compliance of having written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.
Compliance will be reviewed in the QA meeting.

Licensee's Proposed Overall Completion Date: *08/05/2022*

Not Implemented (███ - 01/05/2023)

233b - Lock Manufacturer Statement

43. Requirements

2600.
233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The home does not have a statement from the manufacturer of the SDCU's locking system verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

POC Submission ***Accept ███ - 08/26/2022)***

Please see the attached manufacturer statement.
In the future the DPO and ED will oversee the compliance of having a statement from the manufacturer, specific to

233b - Lock Manufacturer Statement (continued)

that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
-Upon a signal from an activated fire alarm system, heat or smoke detector.
-Power failure to the home.
-Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.
Compliance will be reviewed at QA meeting.

Licensee's Proposed Overall Completion Date: *08/12/2022*

Implemented (- 01/05/2023)

234a - Admission Support Plan

44. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #14 was admitted to the SDCU on however, an initial support plan was not completed within 72 hours of the admission.

Resident #15 was admitted to the SDCU on however, the resident's initial support plan was completed on 3/11/22.

POC Submission ***Accept (08/26/2022)***

Resident #14 Support plan has been updated.
Resident #15 Support plan has been updated.
While working on getting our electronic charting system set up, our assessments were dated completed when we made changes to them. In the future we will monitor our dates closely on our support plans to ensure compliance.
A monthly report of generated at the beginning of each week with dates on when our support plans need renewed or initial support plans need generated. Memory care support plans will be done 72 hours after admission and Personal care will be done 15 days after admission and no later. This will be monitored by the health and wellness director and over seen by the executive director.
Auditing tool will be generated weekly from our Yardi charting system notifying the HWD/ED on what residents will need updated support plans and when. These assessments will be done within the state regulation time frame and filed in the POC binder for compliance.
Support plan compliance will be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented (- 01/05/2023)

252 - Record Content

45. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

252 - Record Content *(continued)*

Description of Violation

Multiple resident records do not include a photograph of the resident that is no more than 2 years old, including records for residents #6, #11, #12, #14, and #15.

POC Submission ***Accept ██ 08/26/2022)***

A picture day was held on August 6th in the dining hall. As each resident entered for all three meals we took their picture and updated their charts.
A spreadsheet was developed with all the names of residents and their date of admission and reviewed monthly for picture updates.
The spreadsheet will be audited by the HWM, RCC or designee and be updated upon admission with all new residents and every 2 years there after.
10% of all charts will be audited weekly starting 8/15/22 for photo compliance within the last 2 years and then audited monthly there after. Photo compliance was added to the chart audit forms.
Photo compliance will be reviewed in QA meeting.

Licensee's Proposed Overall Completion Date: *09/22/2022*

Not Implemented ██ 01/05/2023)