

Department of Human Services
Bureau of Human Service Licensing

December 1, 2022

[REDACTED]
DOUGLASSVILLE AID II OPCO LLC
[REDACTED]
[REDACTED]

RE: AMITY PLACE
139 OLD SWEDE ROAD
DOUGLASSVILLE, PA, 19518
LICENSE/COC#: 22656

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/27/2022, 09/28/2022, 10/14/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: AMITY PLACE License #: 22656 License Expiration: 10/18/2022
Address: 139 OLD SWEDE ROAD, DOUGLASSVILLE, PA 19518
County: BERKS Region: NORTHEAST

Administrator

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

Legal Entity

Name: DOUGLASSVILLE AID II OPCO LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: 1 1 Date: 02/19/2009 Issued By: Amity Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 79 Waking Staff: 59

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Complaint Exit Conference Date: 10/14/2022

Inspection Dates and Department Representative

09/27/2022 On Site [REDACTED]
09/28/2022 On Site [REDACTED]
10/14/2022 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 100 Residents Served: 56

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 14

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 56
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 23 Have Physical Disability: 0

Inspections / Reviews

09/27/2022 - Full

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*

Follow Up Date: *11/06/2022*

11/18/2022 POC Submission

Submitted By: [REDACTED]

Date Submitted: *11/23/2022*

Reviewer: [REDACTED]

Follow Up Type: *Document Submission* Follow Up Date: *11/23/2022*

12/01/2022 Document Submission

Submitted By: [REDACTED]

Date Submitted: *11/23/2022*

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED]/22 Staff A made a medication error. The error was not reported to the Department until [REDACTED]/22. On [REDACTED]/22 Resident #1 passed away. It was not reported to the Department until [REDACTED]/22. On [REDACTED]/22 a medication error occurred with Resident #2's [REDACTED] administration. It was not reported to the Department until [REDACTED]/22.

Plan of Correction

Accept ([REDACTED] - 11/18/2022)

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

- On 11/1/22 the Regional Director of Care Services (RDCS) educated the Executive Director (ED) and Care Services Manager (CSM) on the requirements set within 2600.16.c and Enlivant Policy titled, Incidents and Accidents. (Exhibit A1 – In-service)
- On 11/3/22 the ED trained the CSM on how to complete and submit reportable incidents in the EDs absence to prevent future instances of delayed reporting (Exhibit A2 – In-service)
- On 11/3/22 the ED audited internal incident reports that occurred over the preceding 30 days to ensure incidents or event that's required reporting, were reported. (Exhibit A3 – Audit tool)
- Beginning 11/7/22 the ED or designee will review internal incident reports by the following day for 12 weeks to ensure that an incident that requires reporting under 2600.16c is reported within 24 hours. (Exhibit A4 – Audit tool)
- Results of the audit will be discussed during monthly Quality Improvement (QI) meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date: 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented ([REDACTED] - 12/01/2022)

17 - Record Confidentiality

2. 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 9/27/22 at 2:30pm, a medication administration record binder was observed by Department staff opened on top

17 - Record Confidentiality (continued)

of the medication cart in the hallway, assessable to anyone walking by.

Plan of Correction

Accept ([REDACTED] - 11/18/2022)

- On 9/27/2022, at the time of the finding, the CSM closed the Medication Administration Record binder and stored it in the locked medication cart.
- On 9/27/2022, immediately after the finding, the CSM audited the location and accessibility of the homes second Medication Administration Record binder and validated that the binder was secured in its corresponding medication cart.
- On 11/3/22, the CSM educated the homes current licensed nurses and medication technicians on the requirements set within 2600.17. (Exhibit B1- In-service)
- Beginning 11/7/22, the CSM or designee will audit the accessibility of the home Medication Administration Record twice weekly x 4 weeks, then bi-weekly x 4 weeks, then Monthly x 1 to validate sustained compliance. (Exhibit B2 – Audit tool)
- Results of the audit will be discussed during monthly Quality Improvement (QI) meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date: _1/28/23_.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented ([REDACTED] - 12/01/2022)

23a - Activities of Daily Living Assistance

3. Requirements

2600.

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

Description of Violation

Resident #3 [REDACTED] and needs assistance of 2 for ADLS. On [REDACTED]/22, [REDACTED]/22, [REDACTED]/22, and [REDACTED]/22 Resident #3 waited over an hour for the call bell to be answered. Resident #4 needs assistance of 1 for ADLS. On [REDACTED]/22, and [REDACTED]/22, Resident #4 waited over an hour for the call bell to be answered.

Plan of Correction

Accept ([REDACTED] - 11/18/2022)

- On 11/1/22, the RDCS educated the CSM and ED on Enlivant policy titled, "Activities of Daily Living". (Exhibit C1 – In-service)
- On 11/3/22, the ED queried current residents to ensure assistance with ADL's was being provided by community staff as necessary and as indicated in the resident assessment and support plan. (Exhibit C2 – Audit tool)
- Beginning 11/7/22, the ED or designee will review the call be wait time report twice weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly to ensure residents needs are addressed timely. (Exhibit C3 – Audit tool)
- Beginning 11/14/22, the ED or designee will query five residents twice weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly to ensure assistance with activities of daily living was being provided by the community staff as necessary and as indicated in the resident's assessment and support plan. (Exhibit C4 – Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

23a - Activities of Daily Living Assistance (continued)

Implemented (████) 12/01/2022)

25a - Written Contract and Review

4. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident’s designated person if any, prior to signature.

Description of Violation

Resident #5 was admitted on █████/22. Resident #5 did not sign the contract until █████22, more than 24 hours after moving into the home.

Plan of Correction

Accept (████) 11/18/2022)

- On 11/2/22, the Regional Executive Director (RED) educated the ED and Community Relations Manager (CRM) on the requirements set within regulation 2600.2a.b (Exhibit D1- In-Service)
- On 11/4/22, the ED completed an internal audit of current resident-home contracts to ensure they were signed by the resident or their designated person and to self-identify contracts signed outside of their 24-hour window. (Exhibit D2- Audit tool)
- The ED and/or designee will audit new resident contracts weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly 1 to validate resident-home contracts were signed by the resident and or the resident’s designated person within 24-hours of admission. (Exhibit D3 – Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented (████) 12/01/2022)

85a - Sanitary Conditions

5. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On █████/22 at █████ pm, Resident #6 s glucometer had dried blood on it.

Plan of Correction

Accept (████) - 11/18/2022)

- On 9/27/22, the CSM cleaned and disinfected Resident #6’s glucometer.
- On 9/27/22, the CSM inspected the cleanliness of the other resident’s glucometers, no other instances of dried blood were noted.
- On 11/3/22, the CSM educated the licensed nurses and MTs on how to clean a glucometer per the manufacturer’s nstructions. (Exhibit E1 – In-service)
- Beginning 11/7/22, the CSM or designee will inspect the cleanliness of the resident glucometers twice weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to validate sustained compliance. (Exhibit E2 – In-service)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

85a - Sanitary Conditions (continued)

- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented (████) 12/01/2022)

88a - Surfaces**6. Requirements**

2600.

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

Description of Violation

The emergency exit located near room 108 was covered with cobwebs, leaves, and bugs.

Plan of Correction

Accept (████) - 11/18/2022)

- On 9/28/22 the RDCS cleaned the emergency exit door located near 108, removing the cobwebs, leaves, and bugs on the exterior of the door.
- On 9/28/22 the RDCS cleaned the homes other exit doors.
- On 11/2/22 the Regional Director of Facilities Management (RDFM) in-serviced the ED and Maintenance Technician on the requirements set within 2600.88.a (Exhibit F1 – In-service)
- Beginning 11/7/22 the Maintenance Technician or designee will audit the cleanliness of the homes emergency exit doors weekly x 4, then bi-weekly x 2, then monthly x 4 to validate sustained compliance. (Exhibit F2 – Audit)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 4/28/23.

Licensee's Proposed Overall Completion Date: 04/28/2023

Implemented (████) - 12/01/2022)

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

Residents in rooms █████ and █████ did not have an operable lamp or other source of lighting that could be turned on at bedside.

Plan of Correction

Accept (████) - 11/18/2022)

- On 9/27/22, the RDFM installed push/tap lights at the bedside in resident room numbers █████ and █████
- On 9/27/22, the RDFM audited current resident rooms, notating rooms that required bedside lighting. For rooms noted without bedside lighting, the RDFM installed push/tap lights. (Exhibit G1- Audit tool)
- On 11/1/22, the RDFM educated the ED and Maintenance Technician on the requirements set within 206.101.j. Exhibit G2 – In-service)
- Beginning 11/7/22, the Maintenance Technician or designee will audit 5 resident rooms weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit G3 – Audit tool)

101j7 - Lighting/Operable Lamp (continued)

- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented (████) - 12/01/2022)

103g - Storing Food**8. Requirements**

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

Located in the dry storage area was a partially used bag of egg noodles was not securely closed.

Plan of Correction

Accept (████) - 11/18/2022)

- On 9/27/22, the Chef discarded the partially filled bag of egg noodles.
- On 9/27/22, the Chef audited the homes dry food goods to ensure partially used products were sealed appropriately. No additional instances of unsealed food items were identified. (Exhibit H1- Audit tool)
- On 11/3/22, the ED educated the Chef on the requirements set within regulation 2600.103g. (Exhibit H2 – In-service)
- Beginning 11/7/22, the Chef or designee will audit the homes dry food goods to ensure partially used products were sealed appropriately twice weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit H3- Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented (████) - 12/01/2022)

103i - Outdated Food**9. Requirements**

2600.

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

Description of Violation

Located in the walk-in freezer was a cart of baked goods and desserts. None of the items on the cart were dated. Also located in the freezer was a partially used bag of chicken breasts and a cream pie that were not dated. Located in the dry storage area was a bag of granola, potato chips, and egg noodles that did not have a date they were opened.

Plan of Correction

Accept (████) 11/18/2022)

- On 9/27/22, the chef discarded the unlabeled baked goods, deserts, partially used bag of chicken breasts, cream pie, granola, potato chips, and egg noodles.

103i - Outdated Food (continued)

- On 9/27/22, the Chef audited the homes refrigerator, freezer and dry food goods to ensure foods are labeled and adequately sealed. No additional instances of unsealed or unlabeled food items were identified. (Exhibit I1- Audit tool)
- On 11/3/22, the ED educated the Chef on the requirements set within regulation 2600.103i. (Exhibit I2 – In-service)
- Beginning 11/7/22, the Chef or designee will audit the homes dry food goods, refrigerator, and freezer to ensure foods are labeled and adequately sealed, twice weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit I3- Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented (████) - 12/01/2022)

123a - Exit Doors**10. Requirements**

2600.

123.a. Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

Description of Violation

The exit located near █████ would not open without an excessive amount of force used, preventing immediate egress in the event of an emergency.

Plan of Correction

Accept (████) - 11/18/2022)

- On 9/27/22, the RDFM repaired the exit door near room █████
- On 9/27/22, the RDFM audited the homes emergency doors and validated that they could be opened easily. (Exhibit J1 – Audit tool)
- On 11/2/22, the RDFM educated the ED and Maintenance Technicians on the requirements set within 2600.123.a. (Exhibit J2 – Audit tool)
- Beginning 11/7/22, the Maintenance Technician or designee will audit the homes exit doors to ensure they can be opened easily twice weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit J3 – Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented (████) - 12/01/2022)

132a - Monthly Fire Drill**11. Requirements**

2600.

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

132a - Monthly Fire Drill (continued)

Description of Violation

A fire drill was not conducted in July 2022

Plan of Correction

Accept (████) - 11/18/2022)

- By 11/14/22, the ED will have conducted an unannounced fire drill on each shift. (Exhibit K/L 1 -Drill Log)
- On 11/2/22, The RDFM educated the ED and Maintenance Technician on the requirements set within regulation 2600.132.a. (Exhibit K2 – In-service)
- Beginning 11/14/22, the ED or designee will audit the Fire Drill Log monthly x 3 months to validate an unannounced drill occurs at least once a month (Exhibit K3 – Audit tool)
- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date: 3/3/23.

Licensee's Proposed Overall Completion Date: 03/03/2023

Implemented (████) - 12/01/2022)

132d - Evacuation

12. 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 has less than 8 minutes to evacuate for a fire. On 1/20/22 the fire drill evacuation time was 8 minutes 10 seconds and on 3/11/22 the evacuation time was 8 minutes and 27 seconds.

Plan of Correction

Accept (████) - 11/18/2022)

- By 11/14/22, the ED will have conducted an unannounced fire drill on each shift. (Exhibit K/L 1 – Drill log)
- On 11/2/22, The RDFM educated the ED and Maintenance Technician on the requirements set within regulation 2600.132.d. (Exhibit L1 - In-service)
- On 11/3/22, the Executive Director educated the homes current staff on the homes evacuation procedures and evacuation time limit. (Exhibit L2 – In-service)
- Beginning 11/14/22, the ED or designee will audit the Fire Drill Log monthly x 3 months to validate evacuation times do not exceed 8 minutes. (Exhibit L2- Audit tool)
- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date: 3/3/23.

Licensee's Proposed Overall Completion Date: 03/03/2023

Implemented (████) - 12/01/2022)

141a 1-10 Medical Evaluation Information

13. Requirements

141a 1-10 Medical Evaluation Information (continued)

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 #5's medical evaluation completed on [redacted] 22 did not indicate Resident's weight.

Plan of Correction

Accept ([redacted] - 11/18/2022)

- On 9/28/22, Resident #5's DME was revised by a licensed nurse after seeking clarification of the residents' weight from the health care provider at the time of the resident's assessment. (Exhibit M1- Revised DME)
- On 11/1/22, the RDCS educated the CSM and CRM on the requirements set within regulation 2600.141.a (Exhibit M2- In-Service)
- On 9/28/22, the CSM completed an internal audit of current resident Documentation of Medical Evaluation (DME) forms identify additional assessments with omitted weights. DMEs identified with omissions will be addressed by a licensed nurse and or physician per the DMEs instructions for completion. (Exhibit M3- Audit tool)
- The CSM or designee will audit 3 resident DMEs weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to alidate sustained compliance (Exhibit M4 – Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented ([redacted] 12/01/2022)

185a - Implement Storage Procedures

14. Requirements

2600.

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

Description of Violation

The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident #6 – At [redacted] am on [redacted] //22, the glucometer reading was [redacted] and the Medical Administration Record, MAR, was incorrectly transcribed as [redacted].

Resident #7 - At [redacted] am on [redacted] /22 the reading on the glucometer was [redacted] but was incorrectly transcribed as [redacted].
Resident #8 - At [redacted] am on [redacted] /22 the reading on the glucometer was [redacted] but was incorrectly transcribed as [redacted].

185a - Implement Storage Procedures (continued)

Resident #9 - At [REDACTED] pm on [REDACTED]/22 the reading on the glucometer was [REDACTED] but was incorrectly transcribed as [REDACTED].

Plan of Correction

Accept ([REDACTED] - 11/18/2022)

- On 9/28/22, the CSM notified Resident #6, and their healthcare provider and responsible party (RP) of the error.
- On 9/28/22, the CSM notified Resident #7, and their healthcare provider and RP of the error.
- On 9/28/22, the CSM notified Resident #8, and their healthcare provider and RP of the error.
- On 9/28/22, the CSM notified Resident #9, and their healthcare provider and RP of the error.
- On 11/1/22, the RDCS educated the CSM on the requirements set within 2600.185a and Enlivant policy titled, Blood Glucose Monitoring. (Exhibit N1 – In-service)
- On 11/3/22, the CSM educated the licensed nurses and medication technicians on the requirements set within 2600.185.a and Enlivant policy titled, Blood Glucose Monitoring. (Exhibit N2 – In-service)
- On 11/4/22, the CSM audited the preceeding 10 days of glucometer readings and corresponding transcriptions for residents with glucometers to self-identify additional transcription errors. (Exhibit N3 – Audit tool)
- Beginning 11/7/22, the CSM or designee will audit the current resident glucometers and corresponding transcriptions for resident with glucometers three times per week x 4 weeks, then bi-weekly x 4 weeks, then monthly 1 to validate sustained compliance. (Exhibit N4 – Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented ([REDACTED] - 12/01/2022)

187d - Follow Prescriber's Orders

15. Requirements

2600.

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

Description of Violation

Resident #8 is on a sliding scale. For readings between [REDACTED], [REDACTED]. On [REDACTED] 22, Resident #8's MAR was documented with a blood glucose reading of [REDACTED] instead of the actual reading on the glucometer of [REDACTED], resulting in 6u being administered instead of 8u.

Plan of Correction

Accept ([REDACTED] 11/18/2022)

- On 9/28/22, the CSM notified Resident #8, and their healthcare provider and responsible party (RP) of the error.
- On 11/1/22, the RDCS educated the CSM on the requirements set within 2600.185a and Enlivant policy titled, Blood Glucose Monitoring Policy and Medication Administration Policy. (Exhibit O1 – In-service)
- On 11/3/22, the CSM educated the licensed nurses and medication technicians on the requirements set within 2600.185.a and Enlivant policy's titled, Blood Glucose Monitoring Policy and Medication Administration Policy. (Exhibit O2 – In-service)
- On 11/4/22, the CSM audited the preceeding 10 days of glucometer readings and corresponding transcriptions for residents with glucometers to self-identify additional transcription errors resulting in medication errors. (Exhibit O3 – Audit tool)
- Beginning 11/7/22, the CSM or designee will audit current resident glucometer readings, corresponding

187d - Follow Prescriber's Orders (continued)

transcriptions, insulin orders, and administrations for residents with glucometers weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit O4 – Audit tool)

- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented (████) - 12/01/2022)

224a - Preadmission Screen Form**16. 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 #5's dates of admission is █████/22. Resident #5's prescreen was completed on █████/22.

Resident #9's dates of admission is █████21. Resident #9's prescreen was completed on █████/21.

Plan of Correction

Accept (████) - 11/18/2022)

- On 11/1/22, the RDCS educated the ED, CSM, and CRM of the requirement set within 2600.224.a. (Exhibit P1-In-service)
- On 11/4/22, the ED audited current residents Preadmission Screening Forms to self-identify additional instances of the form being completed outside of the regulated timeframe. (Exhibit P2 – Audit tool)
- Beginning 11/7/22, the ED or designee will audit the Preadmission Screen Form for completion for prospective new admissions weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit P3 – Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented (████) - 12/01/2022)

225a - Assessment 15 Days**17. 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's date of admission is █████/22. Resident's assessment was completed on █████/22.

Resident #5's date of admission is █████22. Resident's assessment was completed on █████/22.

225a - Assessment 15 Days (continued)

Resident #10's date of admission is [REDACTED]/21. Resident's assessment was completed on [REDACTED]/21.

Plan of Correction

Accept [REDACTED] 11/18/2022)

- On 9/28/22 the CSM completed a new Resident Assessment and Support Plan (RASP) for Resident #3 to ensure that the residents needs are being met. (Exhibit Q1 – RASP)
- On 9/28/22 the CSM completed a new RASP for Resident #5 to ensure that the residents needs are being met. Exhibit Q2 – RASP)
- On 9/28/22 the CSM completed a new RASP for Resident #10 to ensure that the residents needs are being met. Exhibit Q3 - RASP)
- On 11/1/22, the RDCS educated the ED and CSM on the requirements set within 2600.225.a. (Exhibit Q4 – In-service)
- By 11/14/22, the CSM audited the RASPs of current residents to ensure they were completed within the regulated timeframe. For RASPs identified to have been completed outside of the regulated timeframe, the CSM or designee completed a new RASP to ensure the residents needs were being met. (Exhibit Q5 – Audit tool)
- Beginning 11/14/22, the CSM will audit the RASPs of new admissions weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 1 to validate sustained compliance (Exhibit Q6 – Audit tool)
- Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date 1/28/23.

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented ([REDACTED] - 12/01/2022)

252 - Record Content

18. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Residents #3, #5, #9 #10, and #11 records do not contain their eye or hair color.

Plan of Correction

Accept ([REDACTED] - 11/18/2022)

- On 11/3/22 the Administrative Specialist updated Resident #3, #5, #9, #10, and #11's face sheet with their eye and hair color. (Exhibit R1 – Audit tool)
- On 11/3/22 the ED educated the Administrative Specialist on the requirements set within 2600.252. (Exhibit R2 – n-service)
- On 11/4/22 the Administrative Specialist audited the homes current residents' records to ensure their race, height, weight, color of hair, color of eyes, religious affiliation and identifying marks are recorded on their respective face sheet. (Exhibit R3 – Audit Tool)
- Beginning 11/14/22 the Administrative Specialist or designee will audit the face sheets of new admissions weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit R4 – Audit tool)
- Results of the audit will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion date: 1/28/23.

252 - Record Content (continued)

Licensee's Proposed Overall Completion Date: 01/28/2023

Implemented ([REDACTED] - 12/01/2022)