

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

January 31, 2023

[REDACTED], ADMINISTRATOR
WG BETHLEHEM SH LLC

RE: ATRIA BETHLEHEM
1745 WEST MACADA ROAD
BETHLEHEM, PA, 18017
LICENSE/COC#: 22281

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/18/2022, 10/19/2022, 10/20/2022 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.

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: ATRIA BETHLEHEM **License #:** 22281 **License Expiration:** 10/16/2023
Address: 1745 WEST MACADA ROAD, BETHLEHEM, PA 18017
County: NORTHAMPTON **Region:** NORTHEAST

Administrator

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

Legal Entity

Name: WG BETHLEHEM SH LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 09/28/1998 **Issued By:** PALI

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 138 **Waking Staff:** 104

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 10/20/2022

Inspection Dates and Department Representative

10/18/2022 - On-Site: [REDACTED]
 10/19/2022 - On-Site: [REDACTED]
 10/20/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 150 **Residents Served:** 113

Secured Dementia Care Unit

In Home: No **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 112
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 25 **Have Physical Disability:** 1

Inspections / Reviews

10/18/2022 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/10/2022

Inspections / Reviews *(continued)*

11/17/2022 POC Submission

Submitted By: [REDACTED] Date Submitted: 11/28/2022
 Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 11/21/2022

11/22/2022 POC Submission

Submitted By: [REDACTED] Date Submitted: 11/28/2022
 Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 11/28/2022

01/31/2023 Document Submission

Submitted By: [REDACTED] Date Submitted: 11/28/2022
 Reviewer: [REDACTED] Follow Up Type: Not Required

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

The most current LIS from [REDACTED] was not posted at time of inspection on [REDACTED].

Plan of Correction

Accept [REDACTED] - 11/16/2022)

? On 10/18/2022 Executive Director posted most recent inspection summary and removed old inspections while inspector was still in the community

? Administrative Assistant and Community Business Director will be educated on 11/14/2022 about the process to ensure that they are able to complete this if the Executive Director is absent

? To ensure ongoing compliance, Executive director will create a calendar reminder to review posted material weekly starting 10/21/2022.

Licensee's Proposed Overall Completion Date: 11/14/2022

Implemented [REDACTED] - 01/31/2023)

57b - 1 Hour/Day

2. Requirements

2600.

57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On [REDACTED] the home had 112 residents in house and are required to staff at least 112 direct care hours. The home was only able to verify that 109.86 direct care hours were staffed this day. On [REDACTED] the home had 113 residents in house and are required to staff at least 113 direct care hours. The home was only able to verify that 110.42 direct care hours were staffed this day. This is a repeat violation from 8/26/2022.

Plan of Correction

Accept [REDACTED] - 11/16/2022)

? Executive Director has recently hired 4 direct care staff

? One hire started 11/9/2022

? Three other new hires will be starting by 11/21/2022

? Executive director/ designee will do an audit of the resident immobile/mobile list and to ensure that the list is accurate starting 11/14/2022 and will match this to direct care hours.

? Executive Director/Care Director will check the care schedule weekly starting 11/21/2022 to ensure that the amount of hours of working direct care staff match the required number of hours for all mobile residents and are visible on the schedule and will document the calculation.

Licensee's Proposed Overall Completion Date: 12/21/2022

Implemented [REDACTED] - 01/31/2023)

57c - 2 Hours/Day

3. Requirements

57c 2 Hours/Day (continued)

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On [REDACTED] the home had a census of 111 residents in house and 25 residents with mobility needs. The home is required to staff at least 136 direct care hours on this day based upon the mobility needs of the residents. The home was only able to verify that 115.02 direct care hours were staffed this day. On 9/24/2022 the home had a census of 112 residents in house and 25 residents with mobility needs. The home is required to staff at least 137 direct care hours on this day based upon the mobility needs of the residents. The home was only able to verify that 109.86 direct care hours were staffed this day. On 9/25/2022 the home had a census of 113 residents in house and 25 residents with mobility needs. The home is required to staff at least 138 direct care hours on this day based the mobility needs of the residents. The home was only able to verify that 110.42 direct care hours were staffed this day. This is a repeat violation from 8/26/2022.

Plan of Correction

Accept [REDACTED] - 11/16/2022)

? Immediate: Executive Director has recently hired 4 direct care staff

? One new hire started 11/9/2022

? Three other new hires will be starting by 11/21/2022

? Executive director/ designee will do an audit of the resident immobile/mobile list and match this to direct care hours 11/14/2022

? Executive Director/Care Director will make sure to do an audit of the care schedule weekly starting 11/21/2022 to ensure that the amount of hours of working direct care staff match the required number of hours for all residents with mobility needs and are visible on the schedule and match this to direct care hours and document the calculation

Licensee's Proposed Overall Completion Date: 11/21/2022

Implemented ([REDACTED] - 01/31/2023)

57d Waking Hours

4. Requirements

2600.

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

Description of Violation

On [REDACTED] the home had a census of 111 residents in house and 25 residents with mobility needs. The home is required to staff 75% of their required 136 direct care hours during daytime hours or 102 direct care hours on this day. The home was only able to verify that 91.71 direct care hours were staff during their daytime hours. On [REDACTED] the home had a census of 112 residents in house and 25 residents with mobility needs. The home is required to staff 75% of their required 137 direct care hours during daytime hours or 102.75 direct care hours on this day. The home was only able to verify that 86.71 direct care hours were staff during their daytime hours. On 9/25/2022 the home had a census of 113 residents in house and 25 residents with mobility needs. The home is required to staff 75% of their required 138 direct care hours during daytime hours or 103.5 direct care hours on this day. The home was only able to verify that 86.32 direct care hours were staff during their daytime hours. This is a repeat violation from 8/26/2022.

57d Waking Hours (continued)

Plan of Correction

Accept (█ - 11/16/2022)

? Executive Director has recently hired 4 direct care staff

? One hire started 11/9/2022

? Other 3 new hires will be starting by 11/21/2022

? Executive Director/Care Director will make sure to do an audit of the care schedule weekly starting 11/21/2022 to ensure that 75% of the all working direct care staff hours are during waking hours

? Executive Director /designee will audit employee files monthly make sure that all staff working in care have an active direct care certificates starting 11/14/2022

Licensee's Proposed Overall Completion Date: 11/21/2022

Implemented (█ - 01/31/2023)

63a - First Aid/CPR Training

5. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On █ and █ the home had 111 and 112 residents in house. They were only able to verify that 2 first aide certified staff members were present from █ pm until █ am. This is a repeat violation from 8/26/2022.

Plan of Correction

Accept (█ - 11/16/2022)

? Classes have been scheduled for completion of training for first aid, CPR and obstructed airway techniques.

? For those who have their certification expiring a class was set up on 10/17/2022

? For those unable to make the class a new one is set up 11/21/2022

? On 10/20/22 Executive Director contacted the agency used for the LPN overnight and requested all credentials (including CPR) Agency informed administration that they have a conducted and audit on 10/22/2022 of their files to make sure their staff are compliant with state.

? Business Director and Care Director completed an audit on 10/15/22 of all staff and agency files to verify that their CPR certifications are up to date.

?

? Business Director created a CPR binder 11/21/2022 This CPR binder will be reviewed monthly starting 11/21/2022 and documented on a checklist that it is reviewed and compliant.

Licensee's Proposed Overall Completion Date: 11/21/2022

Implemented (█ - 01/31/2023)

85d - Trash Receptacles

6. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

85d - Trash Receptacles (continued)

Description of Violation

There were several uncovered garbage cans observed in the kitchen that were not actively being used by staff at time of inspection on 10/20/2022.

Plan of Correction

Accept () - 11/16/2022)

- Immediate: DCS covered garbage cans with available lids and ordered lids that were missing on 10/20/2022
- DCS will educate the culinary staff about always keeping the receptacle lids on the trash by 11/14/22
- DCS will add this task to the daily cleaning list by 11/14/2022

Licensee's Proposed Overall Completion Date: 11/14/2022

Implemented () - 01/31/2023)

85e - Trash Outside Home

7. 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

The dumpster outside of the building was observed with both lids open on 10/18/2022.

Plan of Correction

Accept () - 11/16/2022)

Immediate Corrective Action:

- On 10/20/2022, the Maintenance Director disposed of the stick that was used to prop the recycling bin lids open. He spaced a large, brightly colored, weatherproof sign on the front of the dumpster that states, "THESE LIDS MUST BE KEPT CLOSED."
- On 11/7/2022, the Maintenance Director educated all community staff that it was a violation of state regulations to keep the lids open.
- The Maintenance Director/designee has a Preventative Maintenance task in the PM List to check the dumpster lids daily to ensure the lids are closed as of 11/14/22.

Licensee's Proposed Overall Completion Date: 11/14/2022

Implemented () - 01/31/2023)

87 - Lighting

8. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

There was no lighting found outside of the exit on 1st floor that leads to the gazebo area.

Plan of Correction

Accept () - 11/16/2022)

Plan of Correction

- The Maintenance Director contacted () to install a light outside the exit on 1st floor that leads to the

87 - Lighting (continued)

gazebo area by 11/30/2022.

- The Maintenance Director walked the entire community and confirmed there are no other hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes that have a lack of or nonfunctioning lighting.*
- The Maintenance Director will create a task in the Preventative Maintenance system to check all these areas each month, beginning 11/14/22.*

Licensee's Proposed Overall Completion Date: 11/30/2022

Implemented (████) - 01/31/2023)

103d - Storing Food Off Floor

9. Requirements

2600.

103.d. Food shall be stored off the floor.

Description of Violation

On 10/20/2022 food was observed being stored in their boxes on the floor in the walk-in refrigerator, freezer, and dry good storage room.

Plan of Correction

Accept (████) - 11/16/2022)

Plan of Correction

- The DCS shelved all products that were on the floors in the designated storage areas on 10/20/2022.*
- Culinary staff will be educated by the Director of Culinary Services (DCS) on Regulation 103d on 11/10/2022.*
- The DCS/designee will post a checklist in the kitchen by 11/21/22 to include a check that all items are stored in their storage locations off the floor and document the check weekly.*

Licensee's Proposed Overall Completion Date: 11/21/2022

Implemented (████) - 01/31/2023)

103i - Outdated Food

10. Requirements

2600.

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

Description of Violation

A dented can of beets was observed on the canned good storage rack in the kitchen.

Plan of Correction

Accept (████) - 11/16/2022)

Plan of Correction

- The DCS discarded the dented can from the storage rack on 10/20/2022. An audit was conducted on 10/20/2022 by the DCS to ensure that all cans were in good standing with no additional findings.*
- Current staff will be educated by the DCS on Regulation 103i by 11/10/2022*
- The DCS/designee will post a checklist in the kitchen by 11/21/22 to include a check that there are no outdated, spoiled or dented cans and document the check weekly.*

103i - Outdated Food (continued)

Licensee's Proposed Overall Completion Date: 11/23/2022

Implemented () - 01/31/2023)

105g - Lint Removal and Duct Cleaning

11. Requirements

2600.

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

Description of Violation

The dryer located in the main laundry room was empty but observed with lint still on the lint screen.

Plan of Correction

Accept () - 11/16/2022)

Plan of Correction

- The Maintenance Director removed lint from the lint screen on 10/20/22.
- On 10/20/2022, the Maintenance Director reeducated all housekeeping staff that the lint must be removed from the dryer after each cycle.
- The Maintenance Director/designee will create a task in the Preventative Maintenance system to check dryers weekly, beginning 11/14/22.

Licensee's Proposed Overall Completion Date: 11/10/2022

Implemented () - 01/31/2023)

121a - Unobstructed Egress

12. Requirements

2600.

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

Description of Violation

A wheelchair was observed blocking an exit door that leads from the hall next to the dining room to the outside patio area on 10/18/2022. This is a repeat violation from 8/26/2022.

Plan of Correction

Accept () - 11/16/2022)

- On 10/18/22 the wheelchair was moved to ensure unobstructed access.
- On 10/21/2022, the Maintenance Director placed a temporary, free standing sign in front of the exits doors informing residents to not park their wheelchairs and walkers in that spot. This warning has been added to the Maintenance Director's orientation for all new residents. The Maintenance Director will in-service RSA's and Culinary staff by 11/15/2022 so that they can help resident find alternate seating in the waiting room.
- The Maintenance Director/designee will create a task in the Preventative Maintenance system to check hallways and egress routes to weekly, beginning 11/14/22 to ensure reeducation of residents and staff is effective.

Licensee's Proposed Overall Completion Date: 11/15/2022

Implemented () - 01/31/2023)

124 - Notice to Fire Department

13. 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 most current notification letter to the local fire department dated 8/24/2021 listed immobile residents that was not an accurate reflection of the current immobile list.

Plan of Correction

Accept () - 11/16/2022

-Immediate: On October 19, 2022 Administrative Assistant typed up letter to the fire Department stating the name of the building, the address of the building, the capacity of 150 residents. Also it stated that "some of our residents were immobile and need assistance with evacuation during a fire or a disaster.

- CBD placed copy of letter in file named FIRE DEPARTMENT NOTIFICATION on 10/19/22 and placed in State Binder for review by state surveyors if requested

Licensee's Proposed Overall Completion Date: 11/10/2022

Implemented () - 01/31/2023

132h - Designated Meeting Place

15. Requirements

2600.

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

Description of Violation

On 1/24/2022, the home's fire drill record indicates that a fire drill was conducted with 115 residents in house but only indicates that 111 evacuated the home. There is no reason given to indicate why all of the residents did not evacuate.

Plan of Correction

Accept () - 11/16/2022

Plan of Correction

- The Executive Director reeducated the Maintenance Director on this requirement on 10/20/22.
- The Maintenance Director/designee check the monthly fire drill report to document each resident and if any do not evacuate, the reason will be stated.
- The ED/designee will inspect each monthly fire drill report for the next 90 days to ensure compliance.

Licensee's Proposed Overall Completion Date: 11/10/2022

Implemented () - 01/31/2023

141a 1-10 Medical Evaluation Information

16. Requirements

2600.

141a 1-10 Medical Evaluation Information (continued)

- 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

The DME dated [REDACTED] for Resident 2 was incomplete. The required section on body positioning was left blank. This is a repeat violation from 8/26/2022.

Plan of Correction

Accept ([REDACTED] - 11/16/2022)

The Resident Service Director (RSD)/ designee will complete an audit of current resident DMEs by 11/30/2022, to ensure compliance with regulation 2600 141a. Any issues found during the audit will be addressed immediately. Regional Care Director will provide additional education by 11/18/22 to the Executive Director and Resident Services Director/ designee to ensure compliance with regulation 2600 141a to make sure DMEs are completed within the required timeframe according to regulation and Atria expectations. Regional Care Director will provide additional training to Executive Director and Resident Service Director/designee on move in process to ensure understanding of requirements for obtaining DME and DME completeness prior to move in by 11/18/2022. Executive Director/designee will be meeting with the Resident Services Director/designee weekly starting 11/21/2022 for 90 days to review new resident DMEs to ensure compliance with regulation 2600 141a. Resident Services Director will be responsible to ensure continue compliance with regulation.

Licensee's Proposed Overall Completion Date: 11/21/2022

Implemented ([REDACTED] - 01/31/2023)

141b1 - Annual Medical Evaluation

17. Requirements

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

Description of Violation

The most current DME for Resident 3 was dated [REDACTED]. Resident 4’s most current DME was dated [REDACTED]. Resident 5’s most current DME was dated [REDACTED].

Plan of Correction

Accept ([REDACTED] - 11/16/2022)

- Resident Services Director/ designee will ensure completion of resident # 3, #4, and #5 DME per regulation by 11/21/2022.
- The Resident Service Director (RSD)/ designee will complete an audit of all current resident DMEs by 11/30/2022, to ensure compliance with regulation 2600 141a. Any issues found during the audit will be addressed immediately.
- Regional Care Director will provide additional education by 11/18/2022 to the Executive Director/designee and Resident Services Director/designee to ensure compliance with regulation 2600 141b to make sure DMEs are

141b1 - Annual Medical Evaluation (continued)

completed within the required timeframe (annually) according to regulation and Atria expectations.

- Executive Director will be meeting with the Resident Services Director/designee weekly starting 11/21/2022 to review new DMEs for next 90 days to ensure compliance with regulation 2600 141b. Resident Services Director will be responsible to ensure continue compliance with regulation.

Licensee's Proposed Overall Completion Date: 11/21/2022

Implemented (████) - 01/31/2023)

184a - Resident's Meds Labeled

20. Requirements

2600.

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

Description of Violation

The medication cart had a bottle of █████ that is prescribed for Resident 6. The pharmacy label on the bottle had been spilled upon and left the label unable to be fully read.

Plan of Correction

Accept (████) - 11/16/2022)

- Executive Director or Resident Service Director will order new label or Mucinex medication from pharmacy for resident #6 immediately. Resident Service Director/ designee will check carts for any illegible medication labels by 11/21/2022. Any issues found will be corrected immediately.
- The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication Controls- Access, Storage, and Labeling by 11/18/2022. The Resident Service Director/designee will conduct in-service on this training to medication staff by 11/30/2022.
- The Resident Services Director/designee will audit carts weekly for any illegible medication labels to ensure proper labeling for the next 90 days.

Licensee's Proposed Overall Completion Date: 11/30/2022

Implemented (████) - 01/31/2023)

185a - Implement Storage Procedures

21. Requirements

2600.

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

Description of Violation

Resident 7's glucometer indicated a blood sugar level of █████ on █████ and █████ on █████ 2. The blood sugar was documented in the MAR as █████ and █████ for the corresponding days and time. This is a repeat violation from 8/26/2022.

Plan of Correction

Accept (████) - 11/17/2022)

- Resident Service Director will correct inaccurate glucometer readings completed on █████ and █████ for resident #7 and ensure correct calibration of glucometers immediately. Resident Service Director/designee will audit glucometer readings by 11/18/2022. Any issues found will be corrected immediately.

185a - Implement Storage Procedures (continued)

- The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication Controls- Access, Storage, and Labeling by 11/18/2022. Regional Care Director will also provide education to Executive Director and Resident Service Director on work instruction AL-0004-34 Monitoring Blood Glucose by 11/18/2022 to ensure understanding of policies and processes. The Resident Service Director/designee will conduct in-service on this training to all nursing staff by 11/30/2022.
- The Resident Services Director/designee will review glucometer readings and documentation weekly to ensure proper use and documentation for the next 90 days.

Licensee's Proposed Overall Completion Date: 11/30/2022

Implemented (████) - 01/31/2023)

187a - Medication Record

22. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

6. Dose.

Description of Violation

Resident 8 is prescribed ██████████ daily. The MAR incorrectly indicates that the resident receives 5mg daily.

Plan of Correction

Accept (████) - 11/17/2022)

- Resident Service Director/ designee corrected Resident # 8 medication record to reflect the ordered medication at the correct dosage/ frequency.
- Resident Service Director/designee will complete audit of prescribed orders to ensure medication is in medication carts per the physician order by 11/30/2022. Any issues found will be corrected immediately.
- The Regional Care Director will provide training by 11/18/2022 to the Executive Director and Resident Services Director/designee on the med cart audit process, triple check process aka order verification by 11/18/2022 to ensure understanding of policies and processes related to physician orders and medication ordering and clarification. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 11/30/2022.
- The Resident Services Director/designee will review triple checks a/k/a order verification and med cart audits weekly to ensure proper medication reordering, clarification of orders, and timely receipt of medications for the next 90 days.

Licensee's Proposed Overall Completion Date: 11/30/2022

Implemented (████) - 01/31/2023)

225a - Assessment 15 Days

23. 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 9 was admitted to the home on ██████████ but their assessment was not completed until ██████████.

225a - Assessment 15 Days (continued)

Resident 10 was admitted to the home on [REDACTED] but their assessment was not completed until [REDACTED]

Plan of Correction

Accept ([REDACTED] - 11/22/2022)

225a – Assessment 15 days

Regional Care Director will provide education to the Executive Director and Resident Service Director/ designee by 11/23/2022 on the importance of ensuring resident assessments are completed and signed within 15 days of the admission accordance with regulation 2600 2225a.

Executive Director will meet with Resident Services Director/ designee weekly starting 11/28/2022 for the next 90 days to review all new resident assessments to ensure they are completed and signed per regulation 2600 225a.

Resident Services Director/ designee will be responsible for compliance with regulation.

Completion Date: 11/28/2022

Licensee's Proposed Overall Completion Date: 11/28/2022

Implemented ([REDACTED] - 01/31/2023)

227a - Support Plan 30 Days

24. Requirements

2600.

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

Description of Violation

Resident 9 was admitted to the home on [REDACTED] but their support plan was not completed until [REDACTED].

Resident 10 was admitted to the home on [REDACTED] but their support plan was not completed until [REDACTED]. This is a repeat violation from 8/26/2022.

Plan of Correction

Accept ([REDACTED] - 11/22/2022)

Regional Care Director will provide education to the Executive Director and Resident Service Director/ designee by 11/23/2022 on the importance of ensuring service plans are completed and signed within 30 days of admission in accordance with regulation 2600 227a.

Executive Director will meet with Resident Services Director/ designee weekly starting 11/28/2022 for the next 90 days to review all new resident service plan/support plans to ensure they are completed and signed within 30 days of the admission per regulation 2600 227a. Resident Services Director/ designee will be responsible for compliance with regulation.

Completion Date: 11/28/2022

Licensee's Proposed Overall Completion Date: 11/28/2022

Implemented ([REDACTED] - 01/31/2023)

227d - Support Plan Medical/Dental

25. Requirements

2600.

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

227d Support Plan Medical/Dental (continued)

Description of Violation

The most current RASP for Resident 1 dated [REDACTED] and resident 10 dated [REDACTED] does not indicate that the residents utilize a bed rail. This is a repeat violation from 8/26/2022.

Plan of Correction

Accept [REDACTED] - 11/17/2022)

- Executive Director/Resident Services Director will complete new service plan/support plan for Resident #1 and Resident #10 by 11/11/2022 to ensure the use of bed rails is captured on the support plan.
- Resident Service Director/designee will complete an audit of the current residents' service plans by 11/30/2022, to ensure all bed rails have been captured. Any issues found during the audit will be addressed immediately.
- Regional Care Director will provide additional training to the Executive Director and Resident Services Director/designee by 11/18/2022 to ensure all service plans/support plans are capturing the use of a bed rail if needed. Executive Director will meet with Resident Services Director/designee weekly for the next 90 days to review all new support plans to ensure compliance with capturing bed rails if indicated. Resident Services Director will be responsible for compliance with regulation.

Licensee's Proposed Overall Completion Date: 11/18/2022

Implemented [REDACTED] - 01/31/2023)

252 - Record Content

26. 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

The case record for Resident 9 did not indicate if the resident had any identifying marks.

Plan of Correction

Accept [REDACTED] 11/17/2022)

- Executive Director/Resident Services Director will have residents #9 Profile Addendum completed to capture any identifying marks by 11/15/2022.
- Resident Service Director/designee will complete an audit of the current residents' Profile Addendum 11/30/2022, to ensure compliance with Regulation 2600.252. Any issues found during the audit will be addressed immediately.
- Regional Care Director will provide additional training to the Executive Director and Resident Services Director/designee by 11/18/2022 on the profile addendum and regulation 2600.252 Executive Director will meet with Resident Services Director/designee weekly for the next 90 days to review all new profile addendum forms to ensure compliance with regulation 2600.252. Resident Services Director will be responsible for compliance with regulation.

Licensee's Proposed Overall Completion Date: 11/18/2022

Implemented [REDACTED] - 01/31/2023)