

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

January 24, 2023

[REDACTED]
MAPLE SHADE MEADOWS LP
[REDACTED]
[REDACTED]

RE: MAPLE SHADE MEADOWS SENIOR
LIVING
50 EAST LOCUST STREET
NESQUEHONING, PA, 18240
LICENSE/COC#: 20400

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/29/2022, 11/30/2022 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: MAPLE SHADE MEADOWS SENIOR LIVING **License #:** 20400 **License Expiration:** 11/20/2023
Address: 50 EAST LOCUST STREET, NESQUEHONING, PA 18240
County: CARBON **Region:** NORTHEAST

Administrator

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

Legal Entity

Name: MAPLE SHADE MEADOWS LP
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: 1/1 **Date:** 10/14/2017 **Issued By:** Borough of Nesquehoning

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 95 **Waking Staff:** 71

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 11/30/2022

Inspection Dates and Department Representative

11/29/2022 On Site [REDACTED]
 11/30/2022 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 104 **Residents Served:** 70

Secured Dementia Care Unit

In Home: Yes **Area:** C wing E wing **Capacity:** 38 **Residents Served:** 17

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 70
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 25 **Have Physical Disability:** 1

Inspections / Reviews

11/29/2022 - Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 01/15/2023

01/17/2023 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 01/24/2023
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 01/23/2023

Inspections / Reviews *(continued)*

01/18/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/24/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 01/24/2023

01/24/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/24/2023

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 home did not have the License Inspection Summary (LIS) reports dated 06/09/2022 and 11/14/21 posted in the home as required.

Plan of Correction

Accept (JH - 01/17/2023)

Updated LIS was posted on the day of inspection. Administrator will be responsible for posting all future inspection summaries. Please see photo attachment, where LIS is posted in the lobby.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented (█ - 01/24/2023)

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

During physical site inspection the private dining room was unattended and resident hospital visit paperwork and two empty blisterpacks with resident medication information were left on a table and on the med cart, leaving confidential resident information accessible to unauthorized persons in the home.

Plan of Correction

Accept (█ - 01/17/2023)

Nursing staff was educated via staff meeting regarding 2600.17. Administrator and Director of Nursing also spoke with staff member who left paperwork and blister packs regarding violation and importance of keeping records confidential.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented (█ - 01/24/2023)

18 - Compliance With Laws

3. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home's carbon monoxide (CO) monitors throughout the home had batteries that had not been changed within the past 12 months. The CO monitor's batteries for the gas fireplace were dated 11/14/2021; the CO monitor's batteries for the laundry room in memory care were dated 11/03/2021; the CO monitor's batteries for the B Hall gas boiler were dated 11/18/2021.

18 - Compliance With Laws (continued)

Plan of Correction

Accept (JH - 01/17/2023)

The batteries were changed while inspector was on site. Facility hired an EVS Lead and an additional maintenance employee to ensure all regulations are followed. Administrator had meeting with staff to discuss regulations and requirements. EVS Lead will be responsible for continued compliance on an ongoing basis.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented (- 01/24/2023)

25b - Contract Signatures

4. 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 #1 did not sign their contract dated /2022. Resident #2 did not sign their contract dated /2022. Resident #3 did not sign their contract dated /2022.

Plan of Correction

Accept (- 01/17/2023)

Marketing and admissions team was educated by administrator regarding 2600.25b requirements. Financial coordinator will be responsible for ongoing compliance. Additionally, financial coordinator has audited all resident and staff files to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented (- 01/24/2023)

51 Criminal Background Check

5. Requirements

2600.

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

Description of Violation

The home did not conduct a criminal background check on staff person A who was hired 22.

Plan of Correction

Accept (- 01/17/2023)

Updated criminal background check was completed, 11/29/22. HR/Financial Coordinator was educated that background checks must be completed for all employees, including employees who resign and then return back at a later time. Administrator/Financial Coordinator will be responsible for continued compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented (- 01/24/2023)

60a Staff/Support Plan

6. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident s assessment and support plan.

60a - Staff/Support Plan (continued)

Description of Violation

The home has 70 residents. A total of 25 residents have mobility issues. Seventeen residents reside in the home's memory care unit. On [REDACTED]/22 from [REDACTED]am to [REDACTED]am the home had only 3 staff persons in the home. On [REDACTED]/22 from [REDACTED]pm to [REDACTED]am the home had only 3 staff persons in the home. The home did not have adequate staff to meet the needs of the residents in the event of an emergency during those times.

Plan of Correction

Accept ([REDACTED] - 01/17/2023)

Facility has hired and is continuing to hire additional staff members for all shifts. Director of Nursing and Care Coordinator will be responsible for continued compliance. Current employee schedule attached.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented ([REDACTED] - 01/24/2023)

63a First Aid/CPR Training

7. 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

The home did not have at least 2 staff persons with First Aid and CPR training on the following dates and times: 11/26/2022 from 3pm to 7am and 11/24/22 from 11pm to 7am and 11/19/22 from 11pm to 7am.

Plan of Correction

Accept ([REDACTED] 01/17/2023)

Facility held First Aid/CPR course on 12/15/22 where all employees who were not previously certified, or who had expired CPR/First Aid training, completed the course. Facility is awaiting updated cards. Director of Nursing and Care Coordinator will ensure appropriate ratio of staff is CPR/First Aid certified on an ongoing basis. Please see attached invoice for proof of class being held.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented ([REDACTED] - 01/24/2023)

82c - Locking Poisonous Materials

8. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

During the initial walkthrough two bottles of Dawn dish liquid were found in an unlocked cabinet in the memory care unit's dining area.

Plan of Correction

Accept ([REDACTED] - 01/17/2023)

Dish liquid was immediately removed from cabinet until lock was located. Administrator spoke with staff at meeting regarding the importance of compliance with 2600.82c. Care Coordinator will be responsible to ensure continued compliance. Administrator to periodically check for compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

82c - Locking Poisonous Materials (continued)

Implemented [redacted] - 01/24/2023)

103g - Storing Food

9. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There was a bag of frozen chicken cutlets stored in the kitchen's freezer that was not properly sealed as well as a frozen bag of pancakes in the freezer of the memory care refrigerator that was not sealed properly.

Plan of Correction

Accept [redacted] - 01/17/2023)

Administrator provided staff with education on proper food storage and food safety. Facility has hired new kitchen management effective 12/1/22 who will ensure continued compliance. Administrator to spot check randomly to ensure compliance and safety.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] - 01/24/2023)

121a - Unobstructed Egress

10. 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

During the initial walkthrough it was found that the following exit doors locate outside of the home's secure dementia unit were locked with mag locks that prevented immediate egress and had to be operated by a keypad:
The exit in the Northwest hall leading to the back yard, The B Hall exit door, and the A hall exit door.

Plan of Correction

Accept [redacted] - 01/18/2023)

Facility administrator is working with facility owner in order to become compliant with 2600.121.a. Facility administrator will provide documentation of compliance upon changes made to mag locked doors in NW Hall, B Hall, and A Hall.

Update 1/18/22- Facility owner responsible for fixing the problem. Facility owner purchasing proximity sensors. Proximity sensors will allow doors to open as soon as someone stands in front of them. Proximity sensors expected to be installed before but no later than 2/13/23.
Facility administrator will continue to monitor ongoing compliance.

Licensee's Proposed Overall Completion Date: 02/13/2023

Implemented [redacted] - 01/24/2023)

130e - Hearing Impairment

11. Requirements

2600.

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

Description of Violation

During resident interviews resident #4 stated that they can not hear the fire alarm during drills and do not know a drill is being conducted until staff inform them and evacuate them from the room. During staff interviews it was reported that resident #5 has slept through fire drill alarms and had to be awakened by staff to evacuate. Residents #4 and #5 do not have any type of signaling device installed in their rooms to immediately alert the residents of a fire emergency.

Plan of Correction

Accept [redacted] - 01/17/2023)

Resident #4 who was on hospice services has since passed. Resident #5 was observed by administrator and care coordinator during a fire drill held on 12/6/22. Resident had returned to room from breakfast at time of fire drill. Resident came to doorway when alarm was activated and awaited staff instruction. Administrator is in touch with fire safety expert and security company to purchase devices to be proactive should we admit residents who are unable to hear the alarms in the future. Director of Nursing and Care Coordinator to be responsible for alerting administrator of any residents who have difficulty hearing. Administrator to be responsible for ensuring signaling devices to be placed for any residents who are unable to hear alarm.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] 01/24/2023)

132b - Safety Inspection/Fire Drill

12. 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 home did not conduct a supervised fire drill or a fire safety inspection conducted by a fire safety expert by 12/31/2021 as required. The home's most recent supervised fire drill and fire safety inspection were conducted on 5/10/2022.

Plan of Correction

Accept [redacted] - 01/18/2023)

Current administrator was not in administrator position in 2021. Administration in place in 2021, is no longer with the facility.

As the current administrator, I scheduled fire safety inspection 5/10/22. Administrator will ensure continued compliance with 2600.132.b. Annual fire safety inspection will be scheduled and conducted by [redacted], fire safety expert, no later than May 9, 2023.

update 1/18/22: Administrator is responsible for fixing the issue. Administrator will ensure all requirements of 2600.132.b are met. Facility annual fire inspection and drill scheduled with [redacted], 5/5/23. Facility administrator will monitor ongoing compliance.

Licensee's Proposed Overall Completion Date: 01/18/2023

132b - Safety Inspection/Fire Drill (continued)

Implemented () - 01/24/2023)

132g - Fire Drills Days/Times

13. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home conducted sleeping hour fire drills on the following dates and times: 03/29/2022 at 11:00pm, 06/28/2022 at 6:30am and 08/18/2022 at 06:30am. The home normally has 4 to 5 staff persons scheduled to work the 3rd shift hours of 11pm to 7am. The home has not conducted a fire drill with only minimal staff; the home conducts all fire drills when additional staff are present to assist and when there is a change of shift.

Plan of Correction

Accept () - 01/17/2023)

Alarm was activated on 12/25/22, at 4:47AM, due to a sprinkler malfunction, with 5 staff members in the building. All residents were evacuated in compliance with regulations and into fire safe areas until cleared by police and fire department. Going forward Administrator and EVS lead will hold fire drills in accordance with 2600.132.g. Administrator will be responsible on an ongoing basis for compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented () - 01/24/2023)

141a - Medical Evaluation

14. 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 #1 was admitted to the home on ()/2022. The resident's Documentation of Medical Evaluation (DME) form was completed ()/2021, which was more than 60 days prior to admission.

Resident #3 was admitted to the home on ()/2022. The resident's DME form was completed ()/22, which was also more than 60 days prior to admission.

Plan of Correction

Accept () - 01/17/2023)

Administrator provided education to responsible staff on 2600.141.a. Director of Nursing and Care Coordinator to be responsible to remain in compliance with 2600.141.a, on an ongoing basis. Administrator will periodically audit resident files to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented () - 01/24/2023)

141a 1-10 Medical Evaluation Information

15. 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

The DME form for resident #5 dated [REDACTED]/2022 did not include a list of medications. The DME form for resident #2 dated [REDACTED] 22 did not include a list of medications. The DME for resident #6 dated [REDACTED] 22 was missing the resident’s weight and a list of medications.

Plan of Correction

Accepted [REDACTED] - 01/17/2023)

Administrator provided education to marketing and admissions teams, and director of nursing and care coordinator on how to remain compliant with 2600.141.a. Copies of RCG were provided to Director of Nursing, Care Coordinator, and is available for all staff to review to ensure compliance. Director of nursing and care coordinator to be responsible for continued compliance. Administrator will continue to periodically audit resident files to ensure compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [REDACTED] 01/24/2023)

183e - Storing Medications

16. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer’s instructions.

Description of Violation

The [REDACTED] pen belonging to resident #7 was not dated when the pen was opened. Instructions indicate the pen is to be disposed 28 days after being opened for use.

Plan of Correction

Accepted [REDACTED] 01/17/2023)

Staff was provided education via staff meeting regarding proper labeling and dating of all medications. Med-Techs have been instructed to audit med-carts on a continuing basis. Director of nursing and care coordinator have been conducting spot checks on a weekly basis to ensure compliance. Director of nursing and care coordinator will be responsible for continued compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [REDACTED] 01/24/2023)

185a - Implement Storage Procedures

17. 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 following PRN medications for resident #8 were not available in the medication cart: [redacted], and [redacted]

The following PRN medication for resident #9 were not available in the medication cart: [redacted]

Resident #10 requires [redacted] monitoring 3 times daily for [redacted] administration. On the following dates and times the [redacted] were incorrectly documented on the Medication administration record (MAR): [redacted]/22 the [redacted] pm reading was [redacted] but was documented as [redacted] [redacted]/22 the [redacted] pm reading was [redacted] but was documented as [redacted]

Plan of Correction

Accept [redacted] - 01/17/2023)

Staff was provided education at staff meeting regarding safe storage procedures, having all medications including PRNs on hand in the facility, and correct documentation. All medications that were not available were ordered from pharmacy on the date of inspection. Director of nursing and care coordinator will be responsible for ongoing compliance of regulation.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] 01/24/2023)

187a - Medication Record

18. Requirements

2600.

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

8. Frequency of administration.

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #9 has an order for [redacted] to be taken as needed with snack. The MAR doesn't include a diagnosis or purpose for this medication to indicate when to administer the medication as needed. Also, the pharmacy label for this medication states that the medication is to be taken once daily with a snack.

Plan of Correction

Accept [redacted] - 01/17/2023)

Pharmacy was alerted to ensure diagnosis are indicated for all medications prescribed. Med-techs and director of nursing to be responsible for alerting pharmacy of any discrepancies. New label was ordered from pharmacy for medication on date of inspection.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] 01/24/2023)

187d - Follow Prescriber's Orders

19. Requirements

187d - Follow Prescriber's Orders (continued)

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

Description of Violation

Resident #10 requires [redacted] for [redacted] administration 3 times daily. On [redacted]/22 at [redacted] am the MAR indicates the blood glucose was [redacted]. This reading was not in the resident's [redacted]. Resident #6 did not receive the medication [redacted] on [redacted]/22 at [redacted] am because the medication was not available to administer.

Plan of Correction

Accept (JH - 01/17/2023)

Administrator spoke with staff on the importance of following directions of the prescriber. Staff was alerted to alert administration of any medication that is not available to administer. Director of nursing and care coordinator to be responsible for continued compliance with regulations regarding nursing department.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] - 01/24/2023)

225c - Additional Assessment

20. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #1 was admitted to the home on [redacted]/22. The resident returned to the home from rehab on [redacted]/22 at which time the resident's needs became more substantial and the resident now required [redacted] and with evacuation during emergencies. The home did not complete a new support plan to document the resident's current needs and issues with mobility.

Plan of Correction

Accept [redacted] - 01/17/2023)

Care coordinator and Director of Nursing provided a copy of RCG. Administrator provided education to management on regulations surrounding RASPs, DME's, Preadmission screenings and the importance of 2600.225.c. Director of nursing and care coordinator to be responsible for completing RASPs in compliance with guidelines. Administrator will ensure ongoing compliance of regulations by spot checking resident files.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] 01/24/2023)

227d - Support Plan Medical/Dental

21. Requirements

2600.

227d - Support Plan Medical/Dental (continued)

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.

Description of Violation

Resident #5 is extremely [redacted] and at times has not heard the fire alarm during fire drills according to staff interview. The resident’s support plan dated [redacted] 2022 does not include this information on page 8 in section 2 regarding the [redacted] needs of the resident and plan to meet the need.

Plan of Correction

Accept [redacted] - 01/17/2023)

Care Coordinator updated support plan to include details of resident being [redacted]. Additionally, Resident #5 was observed by administrator and care coordinator during a fire drill held on 12/6/22. Resident had returned to room from breakfast at time of fire drill. Resident came to doorway when alarm was activated and awaited staff instruction. Administrator in touch with fire safety expert to provide signaling devices. Care Coordinator and Administrator to monitor resident response to fire alarms on an ongoing basis and provide signaling devices to residents in need.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] - 01/24/2023)

231b - Medical Evaluation

22. 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 #3 was admitted to the home’s [redacted] unit on [redacted]/22. The DME dated [redacted]/22 originally indicated “other” in section 4 of the DME; the box for secured [redacted] care was marked with an X in ink after the DME was signed by the physician on [redacted]/22.

Resident #6 was admitted to the home’s [redacted] unit on [redacted]/22. The DME dated [redacted] 22 did not indicate the need for secure [redacted] care in section 4 of the DME.

Plan of Correction

Accept [redacted] - 01/17/2023)

Administrator provided education to marketing and admissions team to ensure DME's are adequately completed upon admission. Director of nursing and care coordinator to check all DME's upon admission, when a significant change occurs, and annually as required. Administrator will continue random audits of resident files to ensure compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] - 01/24/2023)

231c - Preadmission Screening

23. Requirements

231c - Preadmission Screening (continued)

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 #2 was admitted to the home's [redacted] unit on [redacted]/22. The cognitive screening was completed [redacted]/22, more than 72 hours prior to admission.

Resident #6 was admitted to the home's [redacted] unit on [redacted] 22. The cognitive screening was completed [redacted]/22, more than 72 hours prior to admission.

Plan of Correction

Accept [redacted] - 01/17/2023)

Marketing and admissions team was provided documentation from RCG regarding preadmission screening requirements and appropriate timelines of documentation. Administrator has been reviewing admission documentation to ensure compliance. Administrator to audit files on an ongoing and random basis to ensure compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] - 01/24/2023)

231e - No Objection Statement

24. 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 #2 was admitted to the home s [redacted] unit on [redacted]/22. The record did not contain a statement signed by the resident and/or designated person indicating no objection to admission to a [redacted] unit.

Resident #6 was admitted to the home s [redacted] unit on [redacted]/22. The record did not contain a statement signed by the resident and/or designated person indicating no objection to admission to a [redacted] unit.

Plan of Correction

Accept [redacted] - 01/17/2023)

Financial coordinator has audited resident files to ensure compliance. Financial coordinator will ensure all resident files are compliant on an ongoing basis. Admission and marketing team was education on 2600.231.e. Administration to spot check files randomly to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [redacted] 01/24/2023)

234a - Admission Support Plan

25. 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 #2 was admitted to the home's [redacted] unit on [redacted] 22. The support plan was due to be completed

234a - Admission Support Plan (continued)

by [REDACTED] 22 but was not completed until [REDACTED] /22.
Resident #6 was admitted to the home's [REDACTED] unit on [REDACTED] /22. The support plan was due to be completed by [REDACTED] /22 but was not completed until [REDACTED] /22.

Plan of Correction **Accepted** [REDACTED] - 01/17/2023)

Care Coordinator and Director of nursing were provided copies of RCG and explained specific dates and deadlines surrounding DME's, support plans, and documentation. Director of nursing and care coordinator responsible for continued compliance. Administrator to continue spot checks of resident files to ensure compliance.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [REDACTED] - 01/24/2023)

251b - Record Entries Legible

26. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid tape was used on resident #6's cognitive screening of the preadmission screening form dated [REDACTED] /22 in the section marked "Printed Name of Person Completing Screening".

Plan of Correction **Accepted** [REDACTED] - 01/17/2023)

Facility policy is that white-out and correction fluid tape is not permitted in facility. Staff member was educated on facility policy. Additionally, administrator spoke to all staff regarding 2600.251.b, and facility policy regarding appropriate documentation and that white out is prohibited.

Licensee's Proposed Overall Completion Date: 01/15/2023

Implemented [REDACTED] - 01/24/2023)