

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

April 7, 2023

[REDACTED]
SUGAR CREEK REST LIMITED PARTNERSHIP
[REDACTED]
[REDACTED]

RE: QUALITY LIFE SERVICES - SUGAR
CREEK
109 PERSONAL CARE LANE
WORTHINGTON, PA, 16262
LICENSE/COC#: 42681

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/20/2022, 12/21/2022 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: *QUALITY LIFE SERVICES - SUGAR CREEK* License #: *42681* License Expiration: *03/29/2023*
 Address: *109 PERSONAL CARE LANE, WORTHINGTON, PA 16262*
 County: *ARMSTRONG* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *SUGAR CREEK REST LIMITED PARTNERSHIP*
 Address: *109 PERSONAL CARE LANE, ATTN EAN KING, WORTHINGTON, PA, 16262*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *12/01/2013* Issued By: *Worthington TWP*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *27* Waking Staff: *20*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *12/21/2022*

Inspection Dates and Department Representative

12/20/2022 - On-Site: [REDACTED]
 12/21/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *47* Residents Served: *20*

Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:

Hospice
 Current Residents: *2*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *18*
 Diagnosed with Mental Illness: *4* Diagnosed with Intellectual Disability: *1*
 Have Mobility Need: *7* Have Physical Disability: *0*

Inspections / Reviews

12/20/2022 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/22/2023*

03/02/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *03/07/2023*
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *03/16/2023*

Inspections / Reviews (*continued*)

04/07/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/07/2023

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. 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 Care Facility Carbon Monoxide Alarms Standard Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. On 12/20/22, the carbon monoxide alarm was directly next to the gas hot water tank/boiler in Armstrong Hallway and approximately 4 feet from the gas dryer in Butler Hallway.

On 12/20/22, the home did not have the Influenza Awareness poster posted in the home.

Plan of Correction

Accept (JW - 03/02/2023)

Carbon Monoxide Detectors

- 1. Maintenance Director ordered 2 new carbon monoxide detectors on 12/30/22 which were placed 15' from the boiler and 15' from the gas dryer.*
- 2. Education provided by Administrator to Maintenance Director and maintenance staff on the Care Facility Carbon Monoxide Alarms Standard Act. Documentation of the education will be kept.*
- 3. Carbon monoxide detectors were mounted in place on 1/11/23 and will be maintained for proper working condition by Maintenance Director or designee.*
- 4. Monthly audits will be conducted beginning 1/16/23 and continuing indefinitely with 1 audit per calendar month to ensure proper functioning of carbon monoxide detectors.*
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.*

Influenza Awareness Poster

- 1. The influenza poster was acquired from the dhs.pa.gov website on 12/23/22 and hung in a public area in the foyer at the main entrance by PC Administrator.*
- 2. Administrator and designee were educated on Chapter 2600 Appendix C as it pertains to influenza by reviewing the Regulatory Compliance Guide.*
"Influenza Awareness Act (NH 1785). Assisted Living Residences must post the required influenza information in a public place in the residence year-round. (Q/A December 2016-2600.18"
- Documentation of education will be kept.*
- 3. The poster will be permanently placed in the home and will only be removed for placement of an updated poster.*
- 4. An audit will be completed by Administrator or designee to ensure poster remains located in public location 1x per week for 4 weeks beginning 1/16/23 and continuing through 2/10/23 to ensure compliance with regulation.*
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.*

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

Implemented (JW - 04/07/2023)

51 - Criminal Background Check

2. Requirements

51 - Criminal Background Check (continued)

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

On 12/21/22, staff person A, hired [REDACTED], did not have a Pennsylvania criminal background check completed. Staff person A worked unsupervised as recent as [REDACTED].

Plan of Correction

Accept (JW - 03/02/2023)

1. Attempted to acquire criminal background check for agency staff member from contracted agency, however background check for necessary staff person and timeframe was unavailable. Said agency staff person has not been, and will not be, scheduled to return to facility since [REDACTED].
2. Education was provided 12/22/22 by Administrator to Human Resources staff regarding Regulation 2600.51. Documentation of education will be kept.
3. Employee files of all current staff were reviewed by PC Administrator and confirmed to have record of completed criminal background check at time of hire. Documentation of a criminal background check will be acquired by Human Resources on new hires and by staffing agency for new agency staff at time of hire or prior to scheduling.
4. An audit will be completed on new hires by Administrator or designee to ensure a criminal background check has been completed before being scheduled for a shift 1x per calendar month for 3 months beginning 1/23/22 and continuing through 4/10/23 to ensure compliance with regulation.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

63a - First Aid/CPR Training

3. 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 12/4/22, from 6:00 am.-11:30 am., 20 residents were present in the home. During this time no staff person was present in the home who was certified in first aid and CPR.

On 12/10/22, from 6:00 pm.-6:00 am., 20 residents were present in the home. During this time no staff person was present in the home who was certified in first aid and CPR.

Plan of Correction

Accept (JW - 03/02/2023)

1. A mandatory CPR/First Aid class was held at facility on 1/2/23. 1 PC Aide was present and certified at this time. All other employee records were reviewed for CPR/First Aid certification - at least 1 staff person on every shift is CPR/First Aid certified or meets qualifications for exemption from training requirements.
2. Education was provided 12/22/22 by Administrator to PC Aides regarding Regulation 2600.63.a. Documentation of education will be kept.

63a - First Aid/CPR Training (continued)

3. Upon hire, new employees will provide proof of current CPR/First Aid certification, proof of licensure that meets qualifications for exemption of training requirements or be scheduled for a CPR/First Aid certification course within the 1st month of employment, during the orientation period. A tracker will be kept by PC Administrator to record date of CPR/First Aid certification and next certification due date. PC Administrator will also ensure at least 1 certified employee per shift is scheduled.
4. An audit will be completed on new hires by Administrator or designee to ensure proof of CPR/First Aid certification prior to hire or within the 1st month of employment 1x per calendar month for 3 months beginning 1/23/22 and continuing through 4/10/23.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

86a - Ventilation

4. Requirements

2600.

86.a. All areas of the home that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

Description of Violation

On 12/20/22, the bathrooms in bedrooms #5, #17, and #25, had no operable window, fan, air conditioner or other mechanical ventilation to ensure airflow.

Plan of Correction

Accept (JW - 03/02/2023)

1. Maintenance Director in to assess all bathroom vents for proper function on 12/30/22. Determined vents were not working in Armstrong hallway for unknown reason. Electrician was contacted on 1/5/23 and scheduled for 1/9/23 to make repairs. Repairs to bathroom vents were finalized on 1/12/23 by the electrician.
2. Education provided by Administrator to Maintenance Director and maintenance staff on Regulation 2600.86.a. Documentation of the education will be kept.
3. Repairs were made to faulty bathroom vents by licensed electrician during site visit on 1/9/23 and 1/12/23 and will then be maintained for proper working condition by Maintenance Director or designee.
4. Monthly audits will be put in place beginning 1/16/23 and continuing indefinitely with 1 audit per calendar month to ensure proper functioning of bathroom vents.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

88a - Surfaces

5. Requirements

88a - Surfaces (continued)

2600.

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

Description of Violation

On 12/20/22, at approximately 2:00 pm., the electrical cord from an oxygen concentrator was running across the floor directly in front of multiple chairs in the dining room into an electrical plug, causing a trip/fall hazard.

Plan of Correction

Accept (JW - 03/02/2023)

1. Oxygen concentrator was repositioned by the Administrator on 12/20/22 so that cord was placed along wall behind chairs, concentrator was positioned next to wall between 2 chairs to prevent tripping hazard. The environment was assessed by the PC Administrator for additional surface hazards, and none were observed.
2. Education provided by Administrator to PC Aides on proper and safe placement of oxygen concentrator when in use and non-use on 12/22/22. Documentation of education will be kept.
3. A caution sign was provided to be placed behind resident when seated at table using supplemental oxygen to caution other residents and staff of oxygen tubing from concentrator to resident and prevent tripping hazard.
4. An audit will be completed by Administrator or designee 5x per week x 1 week and 1x per week for 3 weeks beginning 1/16/23 and continuing through 2/10/23 to ensure compliance with procedure.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

89b - Hot Water Temperature

6. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 12/20/22, at 12:01 pm., the hot water temperature at the bathroom sink in bedroom #20 measured 123 degrees Fahrenheit and at 1:55 pm., it was 124.3 degrees Fahrenheit.

Plan of Correction

Accept (JW - 03/02/2023)

1. Water temperature was immediately turned down by maintenance staff to 118* on day of inspection, 12/20/22.
2. Education provided by Administrator to Maintenance Director and staff on appropriate water temperature in accordance with Regulation 2600.89.b on 12/22/22. Documentation of the education will be kept.
3. Maintenance Director or designee will conduct daily water temperature readings and record in electronic recording system.
4. Daily audits have been conducted by Maintenance Director or designee beginning 12/21/22 and will continue indefinitely.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

90b - Staff Communication

7. Requirements

2600.

90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system that allows staff in different parts of the home to communicate with each other in an emergency. On 12/21/22, the home served 20 residents.

Plan of Correction

Accept (JW - 03/02/2023)

1. Two battery operated walkie-talkies were provided by Maintenance Director on 1/3/23 and were provided to direct care staff.
2. Education was provided by Administrator to PC Aides regarding Regulation 2600.90.b on 1/4/23. Documentation of education will be kept.
3. A walkie-talkie was provided for each med cart so that direct care staff persons have means of communication. Batteries were provided by Maintenance Director on 1/3/23 so that needed supplies are available on-site to prevent disruption of use.
4. An audit will be completed by Administrator or designee to ensure staff compliance with use of communication devices and will be completed 1 x per week for 4 weeks beginning on 1/16/23 and continuing through 2/10/23.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

93a - Handrails

9. Requirements

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On 12/20/22, the ramp outside of the emergency exit door by the laundry room did not have any handrail.

Plan of Correction

Accept (JW - 03/02/2023)

1. Maintenance Director assessed area around ramp on 12/22/22 to determine best option and placement of railing. Railing mounted to brick wall to right of ramp, as you exit building on 1/10/23.
2. Education provided by Administrator on Regulation 2600.93.a to Maintenance Director and staff on 12/23/22 regarding use of ramps and required handrails. Documentation of the education will be kept.
3. Permanent railing will be mounted into brick wall. Any new ramps that are installed on premises will include a railing.
4. There are no other ramps on premises.
5. The addition of any new ramps with railings placed on premises will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

101j7 - Lighting/Operable Lamp

10. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 12/20/22, resident #1, in bedroom #15 did not have access to a source of light that could be turned on/off at bedside.

Plan of Correction

Accept (JW - 03/02/2023)

- 1. Bedside lamp in resident room was observed to not be plugged in. Lamp was plugged in on 12/23/22 and was assessed to be working properly.
- 2. Education provided by Administrator to PC Aide staff in accordance with Regulation 2600.101.j on 12/23/22. Documentation of education will be kept.
- 3. Light bulbs were supplied by maintenance department on 1/3/23 so that needed supplies are available on-site for immediate corrective action.
- 4. Audits will be completed by Administrator or designee 1x weekly for 4 weeks and 1x monthly for 2 months beginning 1/16/23 and continuing through 7/17/23 to ensure compliance with regulation.
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

123b - Emergency Procedures Posted

11. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 12/20/22, the home's and the local municipality's emergency procedures were not posted in a conspicuous and public place in the home.

Plan of Correction

Accept (JW - 03/02/2023)

- 1. The emergency preparedness procedure policy manual was located in a closet in the administrator's office. The policy manual was placed in a conspicuous and public location on 1/6/23 by the Administrator.
- 2. Education provided by Administrator to Maintenance Director and maintenance staff, PC Aides, and ancillary staff on 1/6/23 in accordance with Regulation 2600.123.b. Documentation of education will be kept.
- 3. The policy manual will permanently remain in a public location and will only be removed for revisions and updates to the policy.
- 4. An audit will be completed by Administrator or designee to ensure emergency procedures documentation remains located in public location 1x per week for 4 weeks beginning 1/16/23 and continuing through 2/10/23 to ensure compliance with regulation.
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

130a - Smoke Detector 15 ft Bedroom

12. Requirements

2600.

130.a. There shall be an operable automatic smoke detector located within 15 feet of each bedroom door.

Description of Violation

On 12/20/22, the nearest operable smoke detector to resident bedrooms #9, #11 and #27 is approximately 26 feet from the bedroom door in Armstrong Hallway.

On 12/20/22, the nearest operable smoke detector to resident bedroom #8 is approximately 38 feet from the bedroom door in Butler Hallway.

On 12/20/22, the nearest operable smoke detector to resident bedroom #10 is approximately 28 feet from the bedroom door in Butler Hallway.

Plan of Correction

Accept (JW - 03/02/2023)

- 1. Two new battery-operated smoke detectors were ordered on 12/30/22 and installed in required areas for compliance on 1/3/23 by maintenance staff.*
- 2. Education provided by Administrator to Maintenance Director and staff on placement of smoke detectors in accordance with Regulation 2600.130.a on 12/23/22. Documentation of the education will be kept.*
- 3. Smoke detectors will be permanently placed and maintained for proper working condition by Maintenance Director or designee.*
- 4. Monthly audits will be performed on battery-operated smoke detectors by Maintenance Director or designee beginning 2/1/23 with process continuing indefinitely with 1 audit per calendar month.*
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.*

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

Implemented (JW - 04/07/2023)

132a - Monthly Fire Drill

13. Requirements

2600.

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

Description of Violation

An unannounced fire drill was not held during the month of 12/16/21 and 6/10/22. The home's fire drill log indicated the home did a "silent drill" and no residents were evacuated.

Plan of Correction

Accept (JW - 03/02/2023)

- 1. An unannounced fire drill was completed by maintenance staff on 12/23/22 during night shift with 20/20 residents being evacuated to fire safe areas and recorded.*
- 2. Education provided by Administrator to Maintenance Director, maintenance staff, and PC staff in accordance with Regulation 2600.132.a on 12/22/22. Documentation of the education will be kept.*
- 3. Staff members involved in fire drill procedure were educated on proper procedure on 12/22/22. New hires will be educated on fire drill procedure during orientation period. Silent fire drills will not be conducted.*
- 4. Audits will be completed by Administrator or designee with 1 audit per calendar year for 12 months beginning*

132a - Monthly Fire Drill (continued)

1/16/23 and ending 12/18/23 to ensure compliance with fire drill procedure.
 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

132c - Fire Drill Records

14. Requirements

2600.

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

Description of Violation

The fire drill record for the drill conducted on 9/25/22 did not include the number of residents present in the home at the time of the fire drill.

Plan of Correction

Accept (JW - 03/02/2023)

1. Fire drill was conducted and recorded by maintenance staff on 12/23/22 with 2 PC Aides participating during night shift with 20/20 residents being evacuated to fire safe areas.
2. Education provided by Administrator to Maintenance Director, maintenance staff, and PC staff in accordance with Regulation 2600.132.c on 12/22/22. Documentation of the education will be kept.
3. Staff members involved in fire drill procedure have been educated on proper procedure by Maintenance Director. New hires will be educated on fire drill procedure during orientation period by Maintenance Director of designee.
4. Audits will be completed by Administrator or designee with 1 audit per calendar year for 12 months beginning 1/16/23 and ending 12/18/23 to ensure compliance with fire drill procedure.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

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

Interviews indicate, during the fire drill on 11/10/22, at 3:05 pm., 17 residents were in the home, 5 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. The home's fire drill log indicates on multiple fire drill evacuations not all residents evacuated to a designated meeting place away from the building or within the fire-safe area.

132h - Designated Meeting Place *(continued)*

Plan of Correction

Accept (JW - 03/02/2023)

1. Fire drill was completed on 12/23/22 by maintenance staff during night shift with 20/20 residents being evacuated to designated fire safe areas and recorded.
2. Education provided by Administrator to Maintenance Director, maintenance staff, and PC staff in accordance with Regulation 2600.132.h on 12/22/22. Documentation of the education will be kept.
3. Staff members involved in fire drill procedure have been educated on proper procedure by Maintenance Director. New hires will be educated on fire drill procedure during orientation period by Maintenance Director or designee. All residents in the building at time of fire drill will be evacuated to a designated fire safe area.
4. Audits will be completed by Administrator or designee with 1 audit per calendar year for 12 months beginning 1/16/23 and ending 12/18/23 to ensure compliance with fire drill procedure.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

144c2 - Smoking Area Distance

16. Requirements

2600.

- 144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
 2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The home's designated smoking area is the covered patio outside of the exit door of Armstrong Hallway. However, part of this area is in the direct pathway from the personal care home to the parking lot.

Plan of Correction

Accept (JW - 03/02/2023)

1. Maintenance Director applied yellow tape to pavement outside of Armstrong hallway doorway on 1/4/23 to designate and divide non-smoking area next to building from smoking area in accordance with facility smoking policy.
2. Education was provided by Administrator to Maintenance Director and maintenance staff on Regulation 2600.144.c.2 on 12/26/22. Documentation of the education will be kept.
3. Signage was hung by maintenance staff on building to indicate non-smoking area, and a sign was hung away from building to indicate smoking area.
4. Audits will be conducted by Administrator or designee to ensure signage remains in place and to monitor for compliance with smoking policy and procedure 1x weekly for 4 weeks and 1x monthly for 2 months beginning 1/16/23 and continuing through 7/17/23.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

171b5 - First Aid Kit

17. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

- 5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 12/20/22, the first aid kit in the bus used to transport residents did not include eye coverings, a face shield or a thermometer.

Plan of Correction

Accept (JW - 03/02/2023)

- 1. Goggles, face shield, and thermometer were immediately replaced in First Aid Kit in bus by maintenance staff on day of inspection 12/20/22.
- 2. Education provided by Administrator to Activities Director and staff on list of required items to be kept in First Aid Kit in accordance with Regulation 2600.96.a 12/20/22. Documentation of the education will be kept.
- 3. A list of required items was composed and will be kept on a clipboard and placed in the bus. Staff will be required to check contents of kit during each use of the bus.
- 4. Audits will be completed each time bus is in use by Activities Director or designee beginning 1/16/23 with process continuing indefinitely. Any missing items will immediately be replaced before leaving premises.
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

181c - Self-administration Assessment

18. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 self-administers medications to include Latanoprost Eye Drops and Timolol Eye Drops; however, resident #1 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction

Accept (JW - 03/02/2023)

- 1. Eyes drops found in resident room were immediately removed and disposed of on 12/20/22 by PC Aide.
- 2. Education provided by Administrator to PC Aides regarding Regulation 2600.181.c on 12/20/22. Documentation of education will be kept.
- 3. Staff members were educated on self-administration of medications policy on 12/20/22 and were instructed to refer to resident's support plan to identify if resident has been cleared for self-administration.
- 4. Resident room audits will be completed by Administrator or designee beginning 1/23/23 1x weekly for 2 weeks through 2/3/23 and 1x per calendar month beginning 3/1/23 and continuing indefinitely to monitor for medications in resident rooms and ensure ongoing compliance with regulation.

181c - Self-administration Assessment (continued)

5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

183a - Original Containers and Injections

19. Requirements

2600.

183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 12/20/22, resident #1 had the medication, Timolol Eye Drops in the prescription box labeled Latanoprost Eye Drops. Resident #1 indicated in interview the original prescription box for Timolol Eye Drops was disposed of.

Plan of Correction

Accept (JW - 03/02/2023)

1. Eyes drops found in resident room were immediately removed and disposed of on 12/20/22 by PC Aide.
2. Education provided by Administrator to PC Aides regarding Regulation 2600.183.a on 12/20/22. Documentation of education will be kept.
3. Staff members have been educated on proper storage of medications on 12/20/22. New hires will be educated on proper storage of medications during initial orientation.
4. Resident room audits will be completed by Administrator or designee beginning 1/23/23 1x weekly for 2 weeks through 2/3/23 and 1x per calendar month beginning 3/1/23 and continuing indefinitely to monitor for medications in resident rooms and ensure ongoing compliance with regulation.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

183b - Meds and Syringes Locked

20. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 12/20/22, resident #1 had the medications Latanoprost Eye Drops and Timolol Eye Drops sitting on the stand next to his/her chair. Resident #1 indicated in interview that he/she does not secure the medications, Latanoprost Eye Drops and Timolol Eye Drops when he/she leaved the bedroom. Therefore, the medications, Latanoprost Eye Drops and Timolol Eye Drops are unlocked, unattended, and accessible in resident #1's bedroom when resident #1 leaves the bedroom.

Plan of Correction

Accept (JW - 03/02/2023)

1. Eyes drops found in resident room were immediately removed and disposed of on 12/20/22 by PC Aide.
2. Education provided by Administrator to PC Aides regarding Regulation 2600.183.b on 12/20/22. Documentation of education will be kept.

183b - Meds and Syringes Locked (continued)

- 3. Staff members have been educated on proper storage of medications when resident is authorized to manage own medications on 12/20/22. New hires will be educated on proper storage of medications during initial orientation.
- 4. Resident room audits will be completed by Administrator or designee beginning 1/23/23 1x weekly for 2 weeks through 2/3/23 and 1x per calendar month beginning 3/1/23 and continuing indefinitely to monitor for medications in resident rooms and ensure ongoing compliance with regulation.
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

183e - Storing Medications

21. 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

On 12/20/22, the medications, Latanoprost Eye Drops and Timolol Eye Drops were open, and not dated as to when they were first opened. According to the manufacturer's instructions, Latanoprost Eye Drops and Timolol Eye Drops expire 4 weeks after opening.

Plan of Correction

Accept (JW - 03/02/2023)

- Eyes drops found in resident room were immediately removed and disposed of on 12/20/22 by PC Aide.*
- 2. Education provided by Administrator to PC Aides regarding Regulation 2600.183.e on 12/20/22. Documentation of education will be kept.*
- 3. Staff members have been educated on proper storage of medications including dating of eye drops upon opening on 12/20/22. New hires will be educated on proper storage of medications during initial orientation.*
- 4. Resident room audits will be completed by Administrator or designee beginning 1/23/23 1x weekly for 2 weeks through 2/3/23 and 1x per calendar month beginning 3/1/23 and continuing indefinitely to monitor for medications in resident rooms and ensure ongoing compliance with regulation.*
- 5. Results of audit will be recorded and reviewed in monthly QAPI meeting.*

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

Implemented (JW - 04/07/2023)

184a - Resident's Meds Labeled

22. Requirements

2600.

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

- 1. The resident's name.
- 2. The name of the medication.
- 3. The date the prescription was issued.
- 4. The prescribed dosage and instructions for administration.
- 5. The name and title of the prescriber.

184a - Resident's Meds Labeled (continued)

Description of Violation

Resident #1 is prescribed, Meclizine, 25mg, 1 tab as needed. There are two containers of the medication, Meclizine for resident #1. One pharmacy label for resident #1's Meclizine, indicates 1 tab every 8 hours as needed and the other pharmacy label indicates 1 tab twice a day as needed.

Resident #2 is prescribed, Multivitamin, 1 tab in the morning. The pharmacy label indicates, Tab-A-Vit, 1 tab in the morning.

Plan of Correction

Accept (JW - 03/02/2023)

1. Resident #1 – the prn medication with order inconsistencies was discontinued by the physician on 12/22/22 due to non-use for >3 weeks and due to the original indication for the medication being resolved per the resident. Medication was removed from the med cart and disposed of on 12/22/22.
- Resident #2 - the resident's MAR was updated on 12/22/22 so that the medication name in the order matched the generic name on the medication provided by pharmacy after verification provided from pharmacy that Tab-A-Vite was a generic substitute for Multivitamin.
2. Education provided by Administrator to PC Aides on 12/22/22 to only administer medications when the name on provided medication matches the medication name listed on the MAR. Documentation of education will be kept.
3. New hires will be educated during med tech training class that medication names must match on pharmacy provided medication and in the MAR in order to be administered to a resident.
4. Medication cart audits will be completed by Administrator or designee beginning 1/23/23 1x weekly for 2 weeks through 2/3/23 and 1x per calendar month beginning 3/1/23 and continuing indefinitely to ensure ongoing compliance with proper administration of medications.
5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)

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

Plan of Correction

Accept (JW - 03/02/2023)

1. Resident #3 was admitted on [REDACTED] and had an initial support plan completed on [REDACTED]. This document is retained on the resident's chart. The resident also had a semi-annual support plan completed on [REDACTED], per company policy, and this assessment is also retained on the resident's chart.
2. Administrator and designee reviewed Regulatory Compliance Guide and were educated on Regulation 2600.227.a as it pertains to the timeliness of completion of resident support plans. Documentation of education will be kept.
3. Administrator or designee will review facility documentation system UDA list daily for support plans due and will complete in timely manner.
4. Audits will be completed by Administrator or designee 1x weekly for 4 weeks and 1x per calendar month for 2

227a - Support Plan 30 Days (continued)

months beginning 1/16/23 and continuing through 4/7/23 to ensure compliance with regulation.

5. Results of audit will be recorded and reviewed in monthly QAPI meeting.

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

Implemented (JW - 04/07/2023)