

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

April 26, 2023

[REDACTED], ADMINISTRATOR
HAYES MANOR INC
2210 BELMONT AVENUE
PHILADELPHIA, PA, 19131

RE: HAYES MANOR
2210 BELMONT AVENUE
PHILADELPHIA, PA, 19131
LICENSE/COC#: 14223

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/04/2023 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: HAYES MANOR License #: 14223 License Expiration: 11/15/2023
 Address: 2210 BELMONT AVENUE, PHILADELPHIA, PA 19131
 County: PHILADELPHIA Region: SOUTHEAST

Administrator

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

Legal Entity

Name: HAYES MANOR INC
 Address: 2210 BELMONT AVENUE, PHILADELPHIA, PA, 19131
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: Other Date: 04/12/1985 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 40 Waking Staff: 30

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint Exit Conference Date: 01/04/2023

Inspection Dates and Department Representative

01/04/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 65 Residents Served: 35
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 0
 Number of Residents Who:
 Receive Supplemental Security Income: 2 Are 60 Years of Age or Older: 35
 Diagnosed with Mental Illness: 4 Diagnosed with Intellectual Disability: 3
 Have Mobility Need: 5 Have Physical Disability: 0

Inspections / Reviews

01/04/2023 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/21/2023

01/23/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 01/23/2023
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/28/2023

Inspections / Reviews *(continued)*

04/21/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/27/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/24/2023

04/26/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/24/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. Requirements

2600.

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

Description of Violation

On [REDACTED] at [REDACTED], staff member A reported that resident#1 was not eating or consuming fluids for several days. Resident#1 was sent to the hospital and admitted for dehydration and a COVID infection. The home did not report this incident to the Department until [REDACTED] at [REDACTED].

Plan of Correction

Accept [REDACTED] - 02/01/2023)

1- Regulation reviewed

2- Violation reviewed

3- Why did it happen?

The nurse manager did not report the incident to the department within 24- hours as required.

4- The nurse manager and nursing staff were in-serviced on the requirement by the administrator, this was completed on 1/18/23.

The nurse manager reviewed all current reports.

The nurse manager of designee will report all incidents to DHS Southeastern Regional Office or PCH hotline within the 24- hour time frame as required.

Moving forward the manager or charge nurse will monitor daily nursing for reportable incidents to ensure they are submitted within the allotted time. This began on 1/19/23 and will continue permanently on the 24- hour nursing report.

5- The nursing staff will contact the manager, administrator, or designee on all reportable incidents to ensure requirement is met.

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented [REDACTED] - 04/26/2023)

16d - Final Incident Report

2. Requirements

2600.

16.d. The home shall submit a final report, on a form prescribed by the Department, to the Department's personal care home regional office immediately following the conclusion of the investigation.

Description of Violation

On [REDACTED], staff member A reported that resident #1 had not eaten or consumed fluid for several days. The resident was sent and admitted to the hospital for dehydration and a COVID infection. The home submitted an initial incident report on [REDACTED]. On [REDACTED], the home was informed by the hospital that the resident passed away. The home did not submit a final report to the Department.

Plan of Correction

Accept [REDACTED] - 02/01/2023)

1- Regulation reviewed

2- Violation reviewed

3- Why did it happen?

16d Final Incident Report (continued)

The nursing staff did not submit the final report to DHS.

4 All nursing staff was in serviced by the administrator on how to complete a DHS incident report on 1/18/23. In serviced attached with previous violation 16 C.

The manager reviewed all current reports for accuracy on 1/19/23.

All reports will be observed by the manager to ensure proper completion she started this process on 1/19/23 and will continue to observe daily and a permanent routine.

5 As a second look reports will be reviewed by the administrator weekly this observation began on Friday 1/20/23 and will be maintained weekly by admin or designee.

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented () - 04/26/2023

23a - Activities of Daily Living Assistance

3. Requirements

2600.

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

Description of Violation

The assessment and support plan, dated (), for resident #2 indicates the resident requires assistance with toileting and bladder management every 2 hours. On (), the resident did not receive this assistance as required. At approximately (), resident #2 was observed with a large bulge in () pants. Staff member B checked on the resident's adult brief and reported that the resident was wearing two adult briefs. The use of adult briefs is not mentioned in the resident's assessment and support plan.

Plan of Correction

Accept () - 02/01/2023

- 1 Regulation reviewed
- 2 Violation reviewed
- 3 Why did it happen?

The resident was wearing two adult briefs and there was no mention of the residents requiring adult briefs on her assessment and support plan.

4 All direct care staff was in serviced by the administrator on the use of incontinent items and supplies, and its proper use on residents including bowel and bladder training and frequent toileting. This was completed on 1/19/23.

The resident's assessment and support plan was updated by the nurse manager on 1/6/23 and included.

The nurse manager check all assessments and support plans for the five incontinent residents on 1/11/23.

5 The charge nurse and manager will check residents for toileting and that their clean and dry and wearing one item, and they are being toileted every shift daily and permanently.

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented () - 04/26/2023

51 - Criminal Background Check

4. 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).

51 - Criminal Background Check (continued)

Description of Violation

Staff member C, was re-hired on [redacted] from previous termination date of [redacted] and the home did not complete a background check.

Staff member D, hired on [redacted], did not have a criminal background check completed until [redacted].

Plan of Correction

Accept [redacted] - 02/01/2023)

- 1- Regulation reviewed
- 2- Violation reviewed
- 3- Why did it happen?

The criminal background check for staff person C was not re-ordered after [redacted] lapse in employment. Staff person D check was not ordered on or before [redacted] 1st day of work.

4- The human resource staff member ordered the background check on staff C 1/5/23, please see included.

The regulation was reviewed with HR by the administrator, see enclosed.

HR reviewed all staff files to make sure they were in compliance on 1/6/23.

5- HR will review all new employee files for ordered criminal checks on their 1st day, and for all requirements their 1st week of work.

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented [redacted] - 04/26/2023)

60a - Staff/Support Plan

5. 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.

Description of Violation

On [redacted], resident #2 did not receive assistance with toileting or bladder management, as required by his/her assessment and support plan. According to staff interviews, these services could not be provided due to lack of available direct care staffing in the home. Rather than assisting the resident with toileting and bladder management, staff dressed the resident with two adult briefs to collect urine and bowel contents. The use of adult briefs is not mentioned in the resident's support plan.

Plan of Correction

Accept [redacted] - 02/01/2023)

- 1- Regulation reviewed
- 2- Violation reviewed
- 3- Why did it happen?

The resident was not changed frequently.

4- The nursing staff was in-serviced by the administrator regarding bladder and bowel management and the proper use of incontinent wear on [redacted].

As of 1/19/23 each incontinent resident will be toileted every two hours with the assistance of the staff by escorting them to the bathroom, providing assistance with removal of clothing if necessary and helping them to be seated. The charge nurse or manager will observe staff and assist with resident in toileting on every two hours on rounds daily to ensure procedures are being followed.

As of 1/11/23 the assistance of the manager and administrator will be provided to staff for ADL's according to the

60a - Staff/Support Plan (continued)

schedule to assist staff when needed with incontinent residents. All direct care staff have been notified to ask for assistance. This was communicated during the in-service on 1/19/23.

The staffing schedule was updated to include their ADL's assistance on 1/6/23. Their assistance will be maintained until we acquire more direct care staff.

We have reached out to PCA to evaluate resident for a higher level of care.

The home will continue to search for additional staffing. Please see ad and flyer.

5- The nurse manager and administrator will observe and assist incontinent residents on daily rounds for toileting and incontinent wear this started on 1/11/23..

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented (████) - 04/26/2023)

93b - Railings

7. Requirements

2600.

93.b. Each porch must have a well-secured railing.

Description of Violation

Railing surrounding the porch and going down the steps is rotting and poorly secured.

Plan of Correction

Accept (████) - 02/01/2023)

1- Regulation reviewed

2- Violation reviewed

3- Why did it happen?

The porch railing was in poor condition. It had gone neglected because it is a egress for the independent cottage which has been inhabited for over 10 years.

4- The maintenance staff was made aware of the violation and in-serviced on maintenance requirements and protocol on 1/9/23 by the administrator.

The old porch railing was removed by the two maintenance employees █████ and █████. A new railing was installed and secured to the deck by the maintenance staff. This was completed by 1/11/23. Please pictures included. Upon making daily walking rounds the maintenance manager or his assistant will monitor the condition of the railings and building this started on 1/11/23.

5- As of 1/11/23 the admin or designee will observe on daily rounds the railings and building for all safety issues. This observation will be permanently. Any maintenance issues will be reported for immediate repair.

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented (████) - 04/26/2023)

95 - Furniture and Equipment

8. Requirements

95 - Furniture and Equipment (*continued*)

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The thermostat in room #202 does not work and the heat can not be regulated. The temperature in the room was approximately 85 degrees Fahrenheit.

The third floor and second floor thermostats located in the hallways do are not operating properly and the heat can not be regulated. The temperature in the hallways was approximately 85 degrees Fahrenheit.

Plan of Correction

Accept [REDACTED] - 02/01/2023)

1- Regulation reviewed

2- Violation reviewed

3- Why did it happen?

Some of the thermostats did not work because zone valves needed replacement and parts have been difficult to locate.

4-The administrator reviewed the violation with the maintenance staff and in-serviced them on general maintenance and repair of the building on 1/11/23.

The old zone valves in room 202 and 2nd and 3rd floor hallways were changed with others that were in-occupied rooms. This process was started on 1/6/23 and completed on 1/12/23.

The hallways and residents room windows are opened as needed as of 1/5/23.

There are now fans placed in the 2nd and 3rd floor hallways, and resident rooms to circulate air when necessary.

This was done on 1/5/23.

As of 1/5/23 ice water is placed on every floor each shift for residents.

A request to purchase a new heating system was made to the board of directors during the December meeting, please see attached.

The search for funding is ongoing as we are a non-profit.

5- Upon making daily walking rounds as of 1/5/23 the admin or designee will monitor the building temperatures daily and residents comfortability.

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented [REDACTED] - 04/26/2023)

100a - Exterior - Free of Hazards

9. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The porch on the first floor left wing has a hole on the floor that measures approximately eight inches in length.

Plan of Correction

Accept [REDACTED] - 02/01/2023)

1- Regulation reviewed

2- Violation reviewed

3- Why did it happen?

There was a hole in the porch floor.

100a Exterior Free of Hazards (continued)

- 4 The porch floor was inspected by the maintenance crew and administrator on 1/5/23
The old damaged floor was removed and new floor replaced on 1/9/23.
The area was painted on 1/11/23. The entire project of railings, flooring, and ceiling was completed by 1/18/23.
Please see pictures.
Upon making daily rounds the maintenance staff will observe and check flooring condition for safety. This started on 1/16/23 and will continue permanently.
- 5 Upon making walking rounds the admin or designee will observe floor daily and report to maintenance any ill findings..

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented [REDACTED] - 04/26/2023)

105f - Labeling/Return of Clothes

10. Requirements

- 2600.
- 105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

The home does not have a system to safeguard resident laundry from loss. Resident #3 reported to management that two pairs of pants were lost and that the clothing was not returned within the 24 hour time frame.

Plan of Correction

Accept [REDACTED] - 02/01/2023)

- 1 Regulation reviewed
- 2 Violation reviewed
- 3 Why did it happen?
A resident had missing items from laundry, and the laundry was not returned in 24 hours.
- 4 The housekeeping department searched for the resident missing items and returned them to them on 1/5/23.
They returned all clean and folded laundry to all residents that was in the laundry this was completed by 1/5/23.
A new proven protocol has been re instituted as of 1/9/23, please see attached. 1st and 3rd floors on Monday and Thursday, 2nd floor on Tuesday and Friday, Coach house on Wednesday.
The housekeeping and admin staff were in serviced on 1/9/23 by the administrator on the protocol, please see attached.
The residents were informed on 1/9/23 by the administrator of the system, please see memo sent out.
As of 1/9/23 the housekeeping manager is observing the system for accuracy and its effectiveness by checking the resident's rooms and laundry room before leaving, when she is off other housekeepers are assigned to the task to ensure that the residents receive their laundry within 24 hours. This procedure will be ongoing permanently. Things will only change for unusual circumstances like equipment failure, excess clothing, etc. They will use the independent machines as a back up if needed.
- 5 Upon making walking rounds the admin or designee will check the laundry room to make sure that residents clean laundry has been returned to them daily and question the residents. Daily observation started on 1/9/23.

105f Labeling/Return of Clothes (continued)

Licensee's Proposed Overall Completion Date: 01/25/2023

Implemented (████) - 04/26/2023)

121a - Unobstructed Egress

11. 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

On 01/04/23 at 10 am, yellow tape blocked egress from the home's the left wing of the building. Rooms #2, #3 and #5 are closest to this exit.

Plan of Correction

Accept (████) - 02/01/2023)

- 1 Regulation reviewed
- 2 Violation reviewed
- 3 Why did it happen?

Someone blocked the independent egress porch access off with yellow tape. Those units are empty and have not been occupied for over 10 years.

4 The staff was made aware of the violation by the administrator on 1/5/23. The maintenance crew removed the yellow tape on 1/5/23, and temporarily stabilized the egress exit until they completed the repair on 1/11/23 pictures are included.

The residents in rooms 2,3,4, and 5 never use that exit for emergency egress as our drills navigates them to the ramp because of their wheelchairs and walkers. Wheelchair residents are on the 1 floor, but they were informed of the repair on 1/5/23 by the administrator.

As of 1/6/23 on daily rounds the maintenance manager or █████ assistant will monitor that egress exits are not blocked. This action has become a part of their walking rounds permanently.

5 Upon making daily rounds on 1/6/23 the admin or designee will monitor all egress exits for blockage permanently.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented (████) - 04/26/2023)

164c - Resident Refusal Eat/Drink

12. Requirements

2600.

164.c. If a resident refuses to eat or drink continuously during a 24-hour period, the resident's primary care physician and the resident's designated person shall be immediately notified.

Description of Violation

On █████ staff member A reported that resident #1 refused to eat and drink for several days. The home did not notify the resident's primary care physician or designated person until █████

164c - Resident Refusal Eat/Drink (continued)

Plan of Correction

Accept [REDACTED] - 02/01/2023)

1- Regulation reviewed

2- Violation reviewed

3- Why did it happen?

*The resident was not consuming adequate food or fluid intake.**4- The nursing staff was made aware of the violation. The task begun with the manager on 1/5/23 and continued through 1/16/23 by the administrator during the training on 1/16/23.**The nurse manager and admin reviewed the action of the staff documentation and occurrences that took place.**Resident was admitted on 11/2/22. The staff made family aware of her intake on 11/9/22. Family came in to discuss residents' diet preferences. This meeting included the dietary manager. They also stated that resident has always had low consumption of foods. Despite the dietary changes and staff's encouragement poor consumption continued, please see nursing notes.**The admin pointed out to staff failure to notify the doctor of [REDACTED] decreased intake at its inception.**All direct care staff has been made aware to monitor and report the resident's intake. Training given on 1/16/23 by the administrator, please attached.**The nurse manager will immediately notify and document poor intake (food and fluid) of all residents. The nursing staff will immediately notify the PCP and responsible party. Place the resident on the 24- hour report and monitor the resident and instructed to transfer the resident to the hospital for evaluation.**5- the nurse manager and admin will read the 24- hour reports daily as of 1/11/23 to observe for residents with poor appetites, poor fluid intake, and the residents' monthly weights. This task has become a part of their daily requirements.*

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented [REDACTED] - 04/26/2023)

183d - Prescription Current

13. Requirements

2600.

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

Description of Violation*On [REDACTED], [REDACTED] as needed prescribed for resident #3, was in the home's medication cart; however, the medication was discontinued on [REDACTED]***Plan of Correction**

Accept [REDACTED] - 02/01/2023)

1- Regulation reviewed

2- Violation reviewed

3- Why did it happen?

*The medication was discontinued and not removed from the medication cart.**4- The medication was removed from the med cart on 1/5/23 and properly discarded according to protocol by the nurse manager.**The medication cart was checked for all discontinued medications on 1/9/23 according to the residents MAR's by the nurse manager and charge nurse on duty.**An audit was completed on 1/9/23 by the nurse manager for all residents' current medications please see attached.*

183d Prescription Current (continued)

The nursing staff was in serviced on 1/11/23 to remove discontinue medications when the order is received from the doctor or pharmacy immediately and discard the meds according to policy. Properly document on the MAR and on the 24 hour report for the nurse manager and admin to see so that they can check for the presence of the medications.

5 The nurse manager and admin will read the 24 hour report daily. The nurse manager will check the med cart weekly to look for discontinued medications this begun as of 1/11/23. In her absence the admin or designee will look at the cart.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented [redacted] - 04/26/2023)

185a - Implement Storage Procedures

14. Requirements

2600.

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

Description of Violation

Resident #3 is prescribed [redacted] for [redacted] and [redacted] for [redacted] as needed.

On 01/04/23 these medication(s) were not available in the home.

Plan of Correction

Accept [redacted] - 02/01/2023)

- 1 Regulation reviewed
- 2 Violation reviewed
- 3 Why did it happen?

Resident #3 prn medication was not present on the med cart.

Resident #4 glucometer reading was not recorded on the residents MAR or glucometer flow sheet.

4 The nurse manager contacted the pharmacy on 1/4/23 to request the prn medications for resident #3 and it was noted that the med refill was faxed to the pharmacy on 12/8/22. Please see attached.

The nurse manager was informed by the pharmacy that the refill was not processed because the pharmacy needed a new order and reached out to the PCP to refill the medicine.

The nursing staff will be responsible to follow up with the PCP and pharmacy if the medications are not received by the next day beginning 1/11/23.

The staff was informed of the empty spaces on the MAR and glucometer flow sheet on 1/11/23.

The medication administration protocol was reviewed with the staff on 1/11/23 by the administrator. This review covered medications, MAR's and documentation. In service is included.

The manager completed an audit of the medication cart on 1/9/23 for all medication, MAR's and flow sheets.

5 The med cart will be audited monthly for current meds by the manager. The next audit will take place on 2/9/23.

She will also review the MAR's and glucose flow sheets while doing monthly recaps. This procedure usually takes place starting by the 25th of each month, this depends on when the new orders are received from the pharmacy.

The pharmacy will continue to perform an annual audit. They are expected in June 2023.

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented [redacted] - 04/26/2023)

15. 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 #4 has a physician's order to check his/her blood sugar daily.

On [redacted], resident #4's glucometer showed a reading of [redacted]. The resident's blood sugar reading was not recorded on the Medication Administration Record nor the home's "glucose flow sheet".

On [redacted], resident #4's glucometer showed a reading of [redacted]. The resident's blood sugar reading was not recorded on the Medication Administration Record nor the home's "glucose flow sheet".

Plan of Correction

Accept [redacted] - 02/01/2023)

1- Regulation reviewed

2- Violation reviewed

3- Why did it happen?

Resident #4 glucometer reading was not recorded on the residents MAR or glucometer flow sheet.

4- The nurse manager reviewed all residents MAR's and glucose flow sheets on 1/9/23.

The medication administration protocol and documentation was reviewed with all medication administration staff on 1/11/23 by the administrator, please see enclosed.

The manager completed an audit on the MAR's and glucose flow sheets on 1/9/23.

The nurse manager or designee will check every Friday to make sure that all documentation has been completed weekly. She began this observation on 1/13/23.

5- The manager will complete a MAR check and reading check monthly when completing monthly recaps. This takes place starts on the 25th of the month when we receive the new orders from the pharmacy.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented [redacted] - 04/26/2023)

187b - Date/Time of Medication Admin.

16. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #3 is prescribed [redacted], take 1 tablet by mouth daily and [redacted] - apply thin layer to affected skin twice daily until symptoms resolve then another three days after.

Resident #3's [redacted] medication administration record does not include the initials of the staff person who administered [redacted] on [redacted] at [redacted] and [redacted] on [redacted]

187b - Date/Time of Medication Admin. (continued)

██████████ and ██████████ at ██████████.

Resident #4 is prescribed glucometer check daily. Resident #4's January 2023 medication administration record does not include the initials of the staff person who completed glucometer check on ██████████ and ██████████ at ██████████.

Plan of Correction

Accept (██████████ - 02/01/2023)

- 1- Regulation reviewed
- 2- Violation reviewed
- 3- Why did it happen?

The staff failed to sign out medications as prescribed and failed to record glucometer check.

4- The nurse manager reviewed all residents MAR's and glucose flow sheets for empty spaces on 1/9/23.

The med administration protocol was reviewed with staff on 1/11/23 by the administrator.

The manager completed an audit of the MAR's and glucose flow sheets on 1/9/23.

The nurse manager or designee will check for empty spaces on the MAR's and flow sheets weekly. This process began on 1/13/23 and will continue every Friday.

5- The nurse manager will complete an audit monthly while doing the monthly recaps on all residents. The renewal for medications (recaps) are usually delivered by the pharmacy by the 25th of each month.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented (██████████ - 04/26/2023)

223b - Service Procedures

17. Requirements

2600.

223.b. The home shall develop written procedures for the delivery and management of services from admission to discharge.

Description of Violation

The home does not have written procedures for the delivery and management of services from admission to discharge. Resident #4 requires one on one supervision. The home's description of services indicates that the home does not provide one on one staff supervision for more than 3 days. On ██████████, resident#1 was observed to have one on one supervision throughout the day.

Plan of Correction

Accept (██████████ - 02/01/2023)

- 1- Regulation reviewed
- 2- Violation reviewed
- 3- Why did it happen?

The description of services did not detail the delivery and management of services provided.

4- A new policy and procedure has been developed to indicate the delivery and management of service from admission to discharge by the administrator. The policy was updated on 1/6/23. Please see attached.

The nurse manager and admin reached out to the family on 1/5/23 for discussion they were not available, called again and left messages and did not receive a return call until 1/13/23. The R/P spoke with the nurse manager on 1/13/23 to set up a phone conference. The resident's POA was made aware that a higher LOC is needed on 1/13/23 and a verbal notice was given by the nurse manager. A 30 day written notice was given on 1/19/23 by the administrator, please see email.

223b - Service Procedures (continued)

The nurse manager contacted PCA to complete a evaluation of the resident on [REDACTED] The RP was provided local contacts of neighboring facilities for placement on 1/19/23 by the administrator. With the approval of the POA information regarding the resident has been sent to admissions of nursing home facilities for placement on 1/20/23 by the nurse manager. 5- The all staff will observe for any changes (decline in resident's abilities) to the nurse manager and admin. and place on the 24- hour report. The nurse manager and admin. will assess for proper placement and contact PCP, RP and PCA to evaluate for level of care as needed. This observation begun on 1/11/23.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented [REDACTED] - 04/26/2023)

224a - Preadmission Screen Form

18. Requirements

2600. 224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #5 was admitted to the home on [REDACTED]; however, the resident's preadmission screening form was completed but it is missing the date of prescreening was completed.

Plan of Correction

Accept [REDACTED] - 02/01/2023)

- 1- Regulation reviewed
2- Violation reviewed
3- Why did it happen?

The resident #5 pre-admission screen's date was inserted on [REDACTED] by the nurse manager. The pre-admission screen was completed on [REDACTED]. Please see included.

An audit on resident #5 chart was completed by the nurse manager on [REDACTED].

The manager will review all new resident admission documents within 15 days of admission for completion beginning 1/11/23.

5- The nurse manager will give the administrator or designee the new residents file to review as a second check for compliance beginning 1/11/23.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented ([REDACTED] - 04/26/2023)

225a - Assessment 15 Days

19. 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.

225a Assessment 15 Days (continued)

Description of Violation

Resident #4 was admitted on [redacted]; however, the resident's assessment was not completed until [redacted].

Plan of Correction

Accept [redacted] - 02/01/2023)

- 1 Regulation reviewed
- 2 Violation reviewed
- 3 Why did it happen?

Resident #4 assessment was not completed within 15 days.

4 The resident #4 assessment was completed 2 days after it was due.

The regulation was viewed with the manager and nursing staff on 1/11/23 by the administrator.

The manager checked all residents assessment dates for compliance on 1/11/23.

The manager will review all new resident assessment documentation within 15 days of the admission as of 1/11/23 continually.

5 The manager will highlight on her calendar due dates upon new resident admission, complete the document and give it to the admin or designee to review on the 15th day permanently as of 1/11/23.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented ([redacted] - 04/26/2023)

20. 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 #4's assessment, dated [redacted], does not include the need of one on one supervision and the resident's attempts at elopement.

Plan of Correction

Accept ([redacted] - 02/01/2023)

- 1 Regulation reviewed
- 2 Violation reviewed
- 3 Why did it happen?

The resident #4 assessment did not include the need for 1 on 1 supervision and potential elopement.

4 The resident #4 assessment has been updated by the nurse manager on 1/11/23, please see attached.

The violation was reviewed with the nurse manager and nursing staff on 1/11/23 by the administrator.

The manager will update all assessments and support plans as needed.

The nurse manager completed a review of resident's assessments and support

Plan for accuracy. This was completed by 1/13/23.

The charge nurse's will assist with reviews of all required documentation.

5 The manager or designee will complete a quarterly review of all documentation, This review will begin on 4/1/23 and continue for 1 year to ensure compliance.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented ([redacted] - 04/26/2023)

225a Assessment 15 Days (continued)

227d - Support Plan Medical/Dental

21. 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.

Description of Violation

The assessment for resident #2, dated [REDACTED], indicates the resident has a need for bowel management. The resident's support plan, dated [REDACTED] does not document how this need will be met.

Plan of Correction

Accept [REDACTED] - 02/01/2023)

- 1 Regulation reviewed
- 2 Violation reviewed
- 3 Why did it happen?

Resident#2 assessment indicates the residents need for bowel management but it was not documented on how [REDACTED] needs would be met.

4 The residents support plan was updated on [REDACTED] by the nurse manager to show how [REDACTED] needs would be met. The violation was reviewed with the staff on 1/11/23 by the administrator. A skin care in service was given to the staff on 1/11/23 by the administrator, please see attached.

The staff was in serviced on bowel management on 1/11/23 by the administrator.

The manager reviewed all incontinent residents assessment and support plan documents for accuracy. This was completed by 1/13/23.

5 The manager/designee will observe all assessments and support plans for completion on quarterly review. The quarterly review will begin on 4/1/23 and continue for 1 year for compliance.

Licensee's Proposed Overall Completion Date: 01/26/2023

Implemented [REDACTED] - 04/26/2023)