

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

May 11, 2023

[REDACTED]  
HARRISBURG AL OPERATIONS LLC  
[REDACTED]

RE: VIVA SENIOR LIVING AT  
HARRISBURG  
150 KEMPTON AVENUE  
HARRISBURG, PA, 17111  
LICENSE/COC#: 33805

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/04/2023, 01/05/2023 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: VIVA SENIOR LIVING AT HARRISBURG

License #: 33805

License Expiration: 07/01/2023

Address: 150 KEMPTON AVENUE, HARRISBURG, PA 17111

County: DAUPHIN

Region: CENTRAL

## Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

## Legal Entity

Name: HARRISBURG AL OPERATIONS LLC

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

## Certificate(s) of Occupancy

## Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 71

Waking Staff: 53

## Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint, Incident

Exit Conference Date: 01/05/2023

## Inspection Dates and Department Representative

01/04/2023 On Site [REDACTED]

01/05/2023 On Site [REDACTED]

## Resident Demographic Data as of Inspection Dates

## General Information

License Capacity: 96

Residents Served: 58

## Secured Dementia Care Unit

In Home: Yes

Area: Ground Floor

Capacity: 14

Residents Served: 13

## Hospice

Current Residents: 7

## Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 58

Diagnosed with Mental Illness: 6

Diagnosed with Intellectual Disability: 2

Have Mobility Need: 13

Have Physical Disability: 0

## Inspections / Reviews

## 01/04/2023 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 02/10/2023

## 03/07/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/01/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 03/14/2023

Inspections / Reviews *(continued)*

03/14/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/01/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/28/2023

05/11/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/01/2023

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]/22 at approximately [REDACTED] pm, Staff Person A stated to Resident #1, "You're stressing me out," multiple times. The resident became upset and tearful. The home did not report this incident to the Department until [REDACTED]/22.

On [REDACTED] 22, Staff Person C administered [REDACTED] to Resident #2. Staff Person C is not trained to administer diabetic medication. The home did not report this incident to the Department until [REDACTED]/22.

On [REDACTED]/22, at [REDACTED] pm, Staff Person B recorded Resident #1 in a personal video while sitting on a couch in the living room area of the secure dementia care unit. Staff Person B then posted the video on social media. The home did not report this incident to the Department until [REDACTED]/23.

## Plan of Correction

Accept ([REDACTED] - 03/14/2023)

> Executive Director during this time frame was terminated on [REDACTED]/2023.

> Current staff will be educated by Executive Director and Resident Services Director on 2600.16.c. and guidelines in 2600.15 on 2/1/2023 and 2/21/2023.

> Executive Director will ensure reportable incidents are reported to the Department within 24 hrs.

> Executive Director will ensure Abuse reporting will follow the guidelines in 2600.15 (relating to abuse reporting covered by law)

> Executive Director will ensure all staff have taken mandatory abuse training provided by the department by 3/30/23

> Reportable incidents will be reviewed at monthly Quality Management Meetings. Next meeting to be held 3/23/23. On the 3rd Thursday of the month there after.

Licensee's Proposed Overall Completion Date: 03/23/2023

Implemented ([REDACTED] - 05/09/2023)

## 42b - Abuse

## 2. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

## Description of Violation

On [REDACTED]/22, between the hours of [REDACTED] pm and [REDACTED] am, Resident #3 complained of nausea, vomited approximately 6-10 times and requested multiple times to be sent to hospital. According to interviews with staff, when Resident #3 asked to go to the hospital, Staff Person H stated that he/she would not send the resident out because the hospital would do nothing for an upset stomach and that, [REDACTED] old, older [REDACTED] tend to be babies." At approximately [REDACTED] pm, Staff Person I administered [REDACTED] to Resident #3 despite this medication not being listed on the resident's medication

42b - Abuse (continued)

administration record. Furthermore, staff at the home did not contact emergency services, the resident's physician or the resident's designated person to report his/her declining condition. At approximately [REDACTED] am on [REDACTED]/22, Resident #3 was found deceased in his/her room. The death certificate lists [REDACTED] as the cause of death.

Repeated Violation - 7/19/22 et al

**Plan of Correction**

Directed ([REDACTED] 03/14/2023)

- > Executive Director during this time frame was terminated on 1/3/2023.
- > Resident Care Director was terminated in December.
- >Resident Care Director will educate staff on Residents Rights and their meanings on 2/1/23 and 2/21/23.
- >Resident Care Director will educate care staff on changes in condition and emergency medical plan procedures on 3/14/23
- >Resident Care Director will educate all Med-Techs/Shift leads to notify Resident Care Director, LPN or Executive Director with any change in resident condition 3/14/23

Directed -

- The Administrator/home will re-educate all direct care and ancillary staff on abuse and what to do in a medical emergency by 4/30/23.
- Reports of abuse will be reviewed at monthly Quality Management Meetings. Next meeting to be held 3/23/23. On the 3rd Thursday of the month there after.

Directed Completion Date: 04/30/2023

Implemented ([REDACTED] - 05/09/2023)

42c - Treatment of Residents

**3. Requirements**

- 2600.
- 42.c. A resident shall be treated with dignity and respect.

**Description of Violation**

On [REDACTED]/22 at approximately [REDACTED] pm, visiting family members reported that they overheard Staff Person A tell Resident #1, "You're stressing me out." Staff Person A told this to the resident multiple times. The resident became visibly upset and was in tears.

**Plan of Correction**

Accept ([REDACTED] 03/14/2023)

- > Executive Director during this time frame was terminated on [REDACTED]/2023.

42c - Treatment of Residents (continued)

- > Staff Person A was terminated on [REDACTED]/2022.
- > Resident Care Director will educate staff on Residents Rights and their meanings on 2/1/23 and 2/21/23
- > Resident Care Director will in-service Care Staff on dealing with stress in the healthcare setting on 2/21/23
- >Resident Care Director will educate staff on dealing with dementia behaviors on 2/21/23
- > Resident Care Director will ensure all new staff have dementia training 2/21/23
- >All incidents of violations of dignity and respect will be reviewed at the next Quality Management meeting to be held on 3/23/23. On the 3rd Thursday of the month there after.

Licensee's Proposed Overall Completion Date: 03/23/2023

Implemented ([REDACTED] - 05/09/2023)

42s - Privacy

4. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On [REDACTED]/22, Staff Person B used a personal cell phone and recorded Resident #1 while sitting on a sofa in the SDCU's living room area. Staff Person B encouraged the resident to smile then uploaded the video to social media.

Plan of Correction

Accept ([REDACTED] - 03/14/2023)

- > Executive Director during this time frame was terminated on [REDACTED]/2023.
- > Staff Person B was terminated on [REDACTED] 23.
- > Resident Care Director will educate staff on Residents Rights and their meanings 2/1/23 and 2/21/23
- > Resident Care Director will re-educate staff on Community's phone policy on 2/21/23.
- > Business Office Manager will ensure all new staff have signed off and understand Community phone policy 2/21/23

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented ([REDACTED] - 05/09/2023)

63a - First Aid/CPR Training

5. Requirements

2600.

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

Description of Violation

On [REDACTED] 22, from [REDACTED] pm - [REDACTED] pm, 58 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid and CPR.

On [REDACTED]/22, from [REDACTED] pm - [REDACTED] am, 58 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid and CPR.

## 63a - First Aid/CPR Training (continued)

On [REDACTED]/22, from [REDACTED] pm - [REDACTED] am, 58 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid and CPR.

Repeated Violation - 9/7/22, 7/19/22 et al

## Plan of Correction

Directed ([REDACTED] - 03/14/2023)

- > Executive Director during this time frame was terminated on [REDACTED]/2023.
- > Business Office Manager was terminated on [REDACTED] 23
- > New Director of Business Administration performed an audit of employee files for anyone not currently certified in CPR on 2/29/23
- > CPR class was held on 2/9/2023. A second CPR class will be scheduled.
- > Resident Care Director will ensure there are 1 staff member is certified on each shift for every 50 residents beginning 2/9/23.
- > Business Office Manager has created a Tickler File for First Aid/CPR training. First Aid/ CPR qualified staff will be marked on staffing schedules beginning 3/5/23.

Directed -

- All training needs will be reviewed at monthly Quality Management Meetings. Next meeting to be held 3/23/23. On the 3rd Thursday of the month there after.

Directed Completion Date: 03/23/2023

Implemented ([REDACTED] - 05/09/2023)

## 65a - FS Orientation 1st Day

## 6. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

## 65a - FS Orientation 1st Day (continued)

**Description of Violation**

Staff Person D, whose first day of work was [REDACTED]/22, and Staff Person E, whose first day of work was [REDACTED]/22, did not receive orientation on the following topics on or before the first day worked:

- Evacuation procedures.
- Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- The location and use of fire extinguishers.
- Smoke detectors and fire alarms.
- Telephone use and notification of emergency services.

Repeated Violation - 7/19/22, et al

**Plan of Correction**

Directed ([REDACTED] - 03/14/2023)

- > Executive Director during this time frame was terminated on [REDACTED] 2023.
- > Business Office Manager was terminated on [REDACTED]/23
- > New Director of Business administration performed an audit of all employee files and will work with the RCD and Executive Director to ensure all training is complete 3/30/23
- > New Director of Business administration will audit 5% of employee files on a monthly basis to ensure compliance with staff training beginning 3/7/23.

Directed -

- The Administrator/home will develop and implement a new hire checklist by 3/31/23 to ensure all new hires receive training timely and this will be monitored by Administrator or designee to ensure timeliness and completion.

Directed Completion Date: 03/31/2023

Implemented ([REDACTED] - 05/09/2023)

## 65b - Rights/Abuse 40 Hours

**7. Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

**Description of Violation**

Staff Person D, whose first day of work was [REDACTED]/22, and Staff Person E, whose first day of work was [REDACTED] 22, have not received training on the following topics:

65b - Rights/Abuse 40 Hours (continued)

- Resident rights.
- Emergency medical plan.
- Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- Reporting of reportable incidents and conditions.

Repeated Violation - 7/19/22, et al

**Plan of Correction**

Directed (████) - 03/14/2023)

- > Executive Director during this time frame was terminated on █████ 2023.
- > Business Office Manager was terminated on █████/23
- > New Director of Business administration performed an audit of all employee files and will work with the RCD and Executive Director to ensure all training is complete 3/30/23
- > New Director of Business administration will audit 5% of employee files on a weekly basis to ensure compliance with staff training beginning 3/7/23.

Directed -

- The Administrator/home will develop and implement a new hire checklist by 3/31/23 to ensure all new hires receive training timely and this will be monitored by the Administrator or designee to ensure timeliness and completion.

Directed Completion Date: 03/31/2023

Implemented (████) - 05/09/2023)

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**

At approximately 10:45 am on 1/4/23, a door marked "furnace" in the Secured Dementia Care Unit (SDCU) across from Room #████ was not locked. In this room, sheets of wall materials were found, as well as a 1 gallon can and 5 gallon bucket of paint. Residents in the SDCU have been not been assessed as being capable of recognizing and using poisons safely.

Repeated Violation - 7/19/22, et al

**Plan of Correction**

Accept (████) - 03/14/2023)

- > Executive Director had items removed from furnace room in SCDU on 1/4/23.
- > Executive Director performed an audit of furnace and electrical rooms on 1/5/23.
- > Maintenance Director and RCD in-serviced housekeepers and care staff on keeping furnace/electrical rooms clean of debris and keeping doors locked at all times on 2/21/23

**82c - Locking Poisonous Materials (continued)**

> Maintenance Director/Housekeeping will audit furnace/electrical room daily for one month to ensure they are locked and free of debris beginning 1/8/23

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented (████) - 05/09/2023)

**105g Lint Removal and Duct Cleaning**

**9. Requirements**

2600.

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

**Description of Violation**

On 1/5/23 at approximately 2:45 pm, an approximate 1/3 inch accumulation of lint was observed in the lint trap of the dryer in the 2nd floor laundry room. There were no clothes in the dryer at the time.

Repeated Violation - 7/19/22, et al

**Plan of Correction**

Accept (████) - 03/14/2023)

- > Executive Director performed an audit of all dryers on 1/5/23.
- > Maintenance Director and RCD will in-service staff on the fire risk of lint build up in dryer vents on 2/21/23
- > Maintenance Director posted signs by all dryers that lint must be cleaned out after each use on 2/1/23.
- > Maintenance Director educated housekeeping on frequent checks of dryer vents to ensure they are clean. Sign off sheets posted by dryers 1/8/23.
- > Maintenance Director will audit sign off sheets weekly for 2 months beginning 1/16/23.

Licensee's Proposed Overall Completion Date: 03/30/2023

Implemented (████) - 05/09/2023)

**125a Combustible Storage**

**10. Requirements**

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

**Description of Violation**

At approximately 10:45 am on 1/4/23, in an unlocked room, labeled "furnace," across from Room #████ in the Secured Dementia Care Unit (SDCU), a 1 gallon can and a 5 gallon bucket of paint were observed within 2 feet of the furnace.

**Plan of Correction**

Accept (████) - 03/14/2023)

- > Executive Director performed an audit of furnace and electrical rooms on 1/5/23.
- > Maintenance Director and RCD in-serviced housekeepers on keeping furnace/electrical rooms clean of debris and combustibles. Keeping doors locked at all times on 2/21/23.
- > Maintenance Director/Housekeeping will audit furnace/electrical room daily for one month to ensure they are locked, free of debris, and free of combustibles 1/6/23.

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented (████) - 05/09/2023)

## 141a - Medical Evaluation

## 11. 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 on [REDACTED]/22. The medical evaluation was not completed until [REDACTED]/22.

Resident #4 was admitted on [REDACTED]/22, but a medical evaluation for this resident has not been completed.

## Plan of Correction

Directed ([REDACTED] - 03/14/2023)

- > Executive Director during this time frame was terminated on [REDACTED] 2023.
- > Resident Care Director was terminated in [REDACTED].
- > Resident 1 had a medical evaluation completed on [REDACTED] 2022 which was not placed in file.
- > Resident 4 had a medical evaluation completed on [REDACTED] 22 which was not placed in file.
- > New Resident Care Director will audit all files to ensure all pertinent paper work is organized and placed in resident files beginning 12/30/23
- > Resident Services Director will audit 5% of resident files monthly to ensure compliance with Department guidelines beginning 2/13/23.

Directed -

- The Administrator/home will develop and implement an admission checklist by 3/31/23 to ensure medical evaluations are timely and the Administrator/designee will audit new admission files monthly for 3 months beginning 4/1/23 for timeliness/completion.
- New Resident Care Director will audit all files to ensure all pertinent paper work is organized and placed in resident files beginning 12/30/22 (the date was changed from 2023 to 2022)

Directed Completion Date: 06/30/2023

Implemented ([REDACTED] - 05/09/2023)

## 183a - Original Containers and Injections

## 12. 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 [REDACTED]/22, the [REDACTED] pm medications for Resident #2 had been popped from their blister pack(s) and pre-poured by Staff Person J, as the resident was currently out of the home. Staff Person J instructed Staff Person C to administer the

183a - Original Containers and Injections (continued)

medications upon the resident's return to the home.

Plan of Correction

Accept ( [redacted] - 03/14/2023)

- > Executive Director during this time frame was terminated on [redacted] 2023. > Resident Care Director was terminated in [redacted].
- > Staff member J was counseled by Regional Clinical Director on per pour of medication and medication good practices on 2/3/2023.
- > Resident Services Director will re-educate current med-techs on medication. policies to be completed by 2/28/23

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented ( [redacted] - 05/09/2023)

187a - Medication Record

13. Requirements

2600.

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #5 is prescribed [redacted], [redacted], [redacted], [redacted], and [redacted]. However, Resident #5's medication administration record (MAR) was blank on [redacted]/22 and was not marked with the staff's initials. No exceptions were noted. Also, on [redacted] 22 and [redacted] 22, the MAR for the [redacted]:00 dose of [redacted] was left blank on the MAR. There were no staff initials and no exception noted.

On [redacted] 22 at approximately 1 [redacted] pm, Staff Person I administered [redacted] to Resident #3. Resident #3 had no order for [redacted] nor was the medication included on the resident's MAR. Resident #3's physician was not notified of the administration.

Repeated Violation - 9/7/22, 7/19/22 et al

Plan of Correction

Accept ( [redacted] - 03/14/2023)

- > Executive Director during this time frame was terminated on [redacted] 2023.
- > Resident Care Director was terminated in [redacted].

**187a - Medication Record (continued)**

- > Regional Clinical Director performed an audit of MARS on 2/6/2023.
- > Resident Services Director re-educated med-techs on medication/mar procedures to be completed by 2/28/23
- > Resident Services Director will audit MARs on a weekly basis starting on 2/6/23 for 2 months to ensure medication procedures are being followed

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented ( ) - 05/09/2023)

**187d - Follow Prescriber's Orders****14. Requirements**

2600.

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

**Description of Violation**

On /22, the physician wrote an order for Resident #5 for staff to clean the right and left heel with and to apply triple antibiotic ointment and use dry, sterile dressings daily and pro re nata (PRN). On /22, Resident #5 informed their physician that the dressings hadn't been changed. On /22, the physician rewrote the treatment order and according to the MAR, this treatment was then started on /22.

**Plan of Correction**

Accept ( ) - 03/14/2023)

- > Executive Director during this time frame was terminated on /2023.
- > Resident Care Director was terminated in .
- > Resident Services Director will re-educate med-techs on following the directions of the prescriber to be completed by 2/28/23.
- > Resident Services Director will audit physicians orders for follow through starting on 2/10/2023 for 2 months.

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented ( ) - 05/09/2023)

**190a - Completion Medication Course****15. Requirements**

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

**Description of Violation**

Staff Person F, hired on /20, successfully completed the Department's approved medication administration course on /22, but has had no MAR reviews/observations. On /22, /22, /22 and /22, Staff Person F administered , , and to Resident #5.

Staff Person G, hired on /19, successfully completed the Department's approved medication administration course on /21, but has had no annual practicums with MAR reviews/observations since. On /22 and /22, Staff Person G administered , , and to Resident #5.

Repeated Violation - 9/7/22, 7/19/22 et al

## 190a - Completion Medication Course (continued)

## Plan of Correction

Accept ( ) - 03/14/2023

- > Executive Director during this time frame was terminated on /2023.
- > Resident Care Director was terminated in .
- > All med-techs will have Mar reviews and observations completed by Regional Clinical Director beginning 1/16/23.
- > Resident Care Director will ensure all med-techs are compliant with Medication Administration Guidelines and Community Policies for Medication Administration Administration 1/16/23
- > Executive Director will develop a tracking system to ensure all med techs are trained to begin 3/15/23.

Licensee's Proposed Overall Completion Date: 03/15/2023

Implemented ( ) - 05/09/2023

## 224a - Preadmission Screen Form

## 16. Requirements

2600.

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

## Description of Violation

Residents #4, #6 and #7 did not have preadmission screening forms completed to determine if the needs of the residents could be met by the services provided by the home.

## Plan of Correction

Accept ( ) - 03/14/2023

- > Executive Director during this time frame was terminated on /2023.
- > Resident Care Director was terminated in .
- > Resident 4 and resident 6 are no longer in the community.
- > Resident Care Director has completed Prescreen for Resident 7 on 2/10/23
- > Resident Care Director will ensure all resident have a completed prescreen prior to admission beginning 1/8/23
- > Resident Care Director will perform monthly audit on 5% of resident files to ensure all files are compliant and represent the best care for the resident to begin on 2/13/23
- > The Executive Director will develop a system to ensure all residents documents are completed timely starting 3/30/23

Licensee's Proposed Overall Completion Date: 03/30/2023

Implemented ( ) - 05/09/2023

## 225a - Assessment 15 Days

## 17. Requirements

2600.

**225a - Assessment 15 Days (continued)**

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**

An assessment was not completed for Resident #4, who was admitted to the home on [REDACTED] 22.

An assessment was not completed for Resident #6, who was admitted to the home on [REDACTED] /22.

**Plan of Correction**

Accept ([REDACTED] - 03/14/2023)

- > Executive Director during this time frame was terminated on [REDACTED] 2023.
- > Resident Care Director was terminated in [REDACTED]
- > Resident 4 and resident 6 are no longer in the Community.
- > Resident Care Director will audit all resident files to ensure all assessments are completed and within the guidelines of admission completed on 1/8/23
- > Resident Care Director will perform monthly audit on 5% of resident files to ensure all files are compliant and represent the best care for the resident beginning 2/13/23
- > The Executive Director will develop a system to ensure all residents documents are completed timely starting 3/30/23

Licensee's Proposed Overall Completion Date: 03/30/2023

Implemented ([REDACTED] - 05/09/2023)

**225c - Additional Assessment****18. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.

**Description of Violation**

The most recent assessment for Resident #7, who was admitted on [REDACTED] /21, was completed on [REDACTED] 21.

Repeated Violation - 9/7/22, 7/19/22 et al

**Plan of Correction**

Accept ([REDACTED] - 03/14/2023)

- > Executive Director during this time frame was terminated on [REDACTED] 2023.
- > Resident 7 had a completed RASP on [REDACTED] /22 [REDACTED] that was not placed in file.
- > Resident Care Director will perform monthly audit on 5% of resident files to ensure all files are compliant and represent the best care for the resident beginning 2/13/23.
- > The Executive Director will develop a system to ensure all residents documents are completed timely starting 3/30/23

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented ([REDACTED] - 05/09/2023)

**227d - Support Plan Medical/Dental****19. 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 #3's most recent support plan, dated [REDACTED] 21, was not complete. The support plan indicated the resident needed some physical assistance in the areas of [REDACTED], [REDACTED] the RASP does not indicate a description of the need, plan to meet the need, frequency and responsible party. Resident #3's RASP indicated that the resident required total physical assistance in the areas of [REDACTED] the RASP does not include a description of these needs or plans to meet the needs, frequency and responsible party.

Resident #5, who was admitted on [REDACTED]/22, was ordered and supplied with a bedrail. The resident's assessment and support plan, dated [REDACTED]/22, does not address the need for this rail, nor a plan to protect the resident from the potential hazards of use.

**Plan of Correction**

Accept ([REDACTED] 03/14/2023)

- > Executive Director during this time frame was terminated on [REDACTED] 2023.
- > Resident 3 is no longer in the community.
- > Resident 5 is no longer in the community
- > Resident Care Director will audit resident files to ensure RASPs are filled out in their entirety completed 1/8/23
- > Resident Care Director will perform monthly audit on 5% of resident files to ensure all files are compliant and represent the best care for the resident beginning 2/13/23
- > The Executive Director will develop a system to ensure all residents documents are completed timely starting 3/30/23

Licensee's Proposed Overall Completion Date: 03/30/2023

Implemented ([REDACTED] - 05/09/2023)

## 227h - Support Plan Refuse Sign

**20. Requirements**

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

**Description of Violation**

Resident #3 did not sign the annual support plan, dated [REDACTED] 21. The home did not make a notation regarding the resident's inability or refusal to sign.

Resident #5 did not sign the annual support plan, dated [REDACTED]/22. The home did not make a notation regarding the resident's inability or refusal to sign.

## 227h - Support Plan Refuse Sign (continued)

**Plan of Correction****Accept (MD - 03/14/2023)**

- > Executive Director during this time frame was terminated on [REDACTED]/2023.
- > Resident 3 and Resident 5 are no longer in the Community.
- > Resident Services Director will audit all resident files to ensure the Resident signature are on the annual support plan or a notation is made of inability to sign or refusal to sign beginning 12/30/22 completed on 1/20/23.
- > Executive Director will educate RCD and Med Techs on the signing of RASPS. RCD will be responsible for the documentation on RASPS to complete on 3/14/23.

**Licensee's Proposed Overall Completion Date: 03/14/2023****Implemented ([REDACTED] - 05/09/2023)**

## 252 - Record Content

**21. Requirements**

2600.

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

3. A photograph of the resident that is no more than 2 years old.

**Description of Violation**

Resident #4 was admitted on [REDACTED] 22, but the resident's record does not include a photograph.

**Plan of Correction****Directed ([REDACTED] - 03/14/2023)**

- > Executive Director during this time frame was terminated on [REDACTED] 2023.
- > Business office manager terminated on [REDACTED]/23
- > New Business office manager start on [REDACTED] 23
- > Business office manager performed an audit of resident files on 1/10/2023
- > Business office manager confirmed all residents had photos in files on 2/8/2023
- > Business office manager will ensure all residents have photos in file and in system on day of move in beginning 1/28/23
- > Resident Care Director will perform monthly audit on 5% of resident files to ensure all files are compliant and represent the best care for the resident beginning 12/30/22

Directed -

- The Administrator/designee will develop a new admission checklist and add photos to this to ensure that photos are taken at admission and a tickler file or calendar reminder will be done to ensure photos are redone every 2 years. This will begin 4/1/23

**Directed Completion Date: 03/31/2023****Implemented ([REDACTED] - 05/09/2023)**