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

March 1, 2023

[redacted], AUTHORIZED PERSON
WELLTOWER OPCO GROUP LLC
[redacted]

RE: SUNRISE OF MCCANDLESS
900 LINCOLN CLUB DRIVE
PITTSBURGH, PA, 15237
LICENSE/COC#: 44880

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/10/2023, 01/11/2023, 01/12/2023 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: *SUNRISE OF MCCANDLESS* **License #**: *44880* **License Expiration**: *12/15/2023*

Address: *900 LINCOLN CLUB DRIVE, PITTSBURGH, PA 15237*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *WELLTOWER OPCO GROUP LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/19/2008* **Issued By**: *Twp of McCandless*

Type: *I-2* **Date**: *01/31/2020* **Issued By**: *Twp of McCandless*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *123* **Waking Staff**: *92*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint* **Exit Conference Date**: *01/12/2023*

Inspection Dates and Department Representative

01/10/2023 - On-Site: [redacted]
01/11/2023 - On-Site: [redacted]
01/12/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *153* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd floor Reminiscence* **Capacity**: *40* **Residents Served**: *22*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *50* **Have Physical Disability**: *0*

Inspections / Reviews

01/10/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/03/2023*

Inspections / Reviews *(continued)*

02/10/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/28/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/01/2023*

03/01/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/28/2023*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 1/10/23, at approximately 9:30 a.m., the home's license posted behind the front desk expired 12/15/22. The current license was not posted in the home.

Plan of Correction ***Accept [redacted] - 02/10/2023)***

The community posted the current license issued by the department at the time of inspection
The Executive Director and Concierges will be provided re-training to ensure the current license is posted timely in a conspicuous and public place. Training will be completed by 2/28/23.
The Executive Director will audit required postings on a monthly basis to ensure compliance with 2600.3c beginning 2/1/23 and ongoing.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 12 months, the committee will review the monthly posting audits to ensure license and current license inspection summary (s) are posted in a conspicuous and public place.

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

Implemented ([redacted] - 03/01/2023)

85e - Trash Outside Home

2. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 1/10/23, at approximately 10:45 a.m., there were multiple areas of uncovered trash outside of the home, including:

- *an uncovered garbage can leaning against the porch rail outside of the smoking room, ¼ full of trash.*
- *approximately 4 dozen cigarette butts on the ground from the porch to the shed near the dumpster.*
- *a large white plastic tub next to the shed, 1/3 full of cigarette butts, used food and beverage containers.*
- *trash scattered on the ground between the shed and the wooden dumpster enclosure wall.*
- *inside the first dumpster area, the side door of the dumpster was open, exposing multiple bags of trash.*
- *a slim jim trash can inside the second dumpster enclosure, 1/3 full of trash.*

Plan of Correction ***Accept ([redacted] - 02/10/2023)***

With respect to reg.2600.85e , on 1/10/23 the Maintenance Coordinator immediately removed and disposed of trash and cigarette butts as well as uncovered garbage cans from the porch rail, grounds, shed and wooden dumpster areas. The dumpster was closed .
All staff will be provided retraining by the Executive Director/Designee, on ensuring trash outside the home is kept in covered receptacles that prevent the penetration of insects and rodents by 2.28.23
The Maintenance Coordinator/Designee will make daily rounds outside the community to ensure trash is secured in covered receptacles . The Executive Director will monitor during weekly outdoor rounds to ensure compliance with 2600.85e beginning 2/15/23 and ongoing.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will

85e Trash Outside Home (continued)

review results of daily/weekly walkthroughs to ensure trash outside the home is kept in covered receptacles that prevent the penetration of insects and rodents. Any incidents of uncovered trash will be reviewed and an action plan will be implemented.

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

Implemented ([redacted] - 03/01/2023)

88a - Surfaces

3. Requirements

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 1/11/23, at 2:10 p.m., there were 2 holes in the wall behind the resident #1's bed, measuring 4" x 6" and 5" x 9", and plaster was covering the floor.

Plan of Correction ***Accept ([redacted] - 02/10/2023)***

With respect to 2600.88a the two holes in the wall behind the resident #1's bed were repaired by the Maintenance Coordinator at the time of inspection 1/12/23.
All staff will be provided re training by the Executive Director/designee by 2/28/23,on identifying any issues with floors, walls, ceilings, windows, doors and other surfaces to ensure they are clean, in good repair and free of hazards as well as procedure to put any identified issues in the communities electronic TEL's system for timely correction by Maintenance/housekeeping staff .
Care Coordinators/Designees will make daily rounds on their neighborhoods and the Executive Director/Maintenance Coordinator will do weekly community walkthrough rounds to ensure all surfaces are clean and in good repair. Any issues will be entered in the communities electronic TEL's system for timely correction by Maintenance/Housekeeping staff 2/15/23 and ongoing .
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review results of daily/weekly walk throughs and TEL's system reports to ensure any issues identified were corrected/repaired timely. An action plan will be developed if any items have not been addressed.

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

Implemented ([redacted] - 03/01/2023)

92 - Windows

4. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 1/10/23, at 9:46 a.m., there were no screens present in 8 of the windows in the main dining room, and the screen in the window on the right side of the dining room had 7 large holes, with the largest measuring 5" long x 1" wide.

On 1/10/23 at 11:08 a.m., there were no screens present in the 2 of the windows in the 4th floor lounge.

92 - Windows (continued)

On 1/10/23, at approximately 11:20 a.m., there was no screen present in the right side of the double set of windows in the 3rd floor Secure Dementia Care Unit (SDCU) dining room.

Plan of Correction ***Accept ([redacted] - 02/10/2023)***

In regards to 2600.92 windows, including windows in doors must be in good repair and securely screened when doors or windows are open. The eight window screens missing and the damaged screen, in the main dining room, two missing screens in the 4th floor lounge and one screen missing in the 3rd floor secure dementia care unit dining room were replaced and secured by the Maintenance Coordinator on 2/8/23.
All staff will be provided re-training by the Executive Director/designee by 2/28/23,on identifying any issues with Missing or damaged screens as well as procedure to put any identified issues in the communities electronic TEL's system for timely correction by Maintenance staff .
Maintenance Coordinator will conduct an audit on all community windows and order screens identified to be missing or damaged by 2/28/23 . Screens will be installed upon delivery.
Care Coordinators/Designee will make daily rounds on their neighborhoods and the Executive Director/Maintenance Coordinator will do weekly community walkthrough rounds to ensure all window screens are in place and in good repair. Any issues will be entered in the communities electronic TEL's system for timely replacement by Maintenance Coordinator/Designee -2/28/23 and ongoing .
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review results of daily/weekly walk throughs and TEL's system reports to ensure any missing or damaged screens are ordered and replaced upon delivery. An action plan will be developed if any items have not been addressed.

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

Implemented [redacted] - 03/01/2023)

101j7 - Lighting/Operable Lamp

5. 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 1/11/23, at 2:18 p.m., resident #2's bedside lamp was not plugged in and there was no other source of light that could be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 02/10/2023)***

In regards to 2600.101j 7, resident #2's bedside lamp identified to be unplugged was plugged in by the Resident Care Director at time of inspection on 1/11/23.
All staff will be provided retraining by the Executive Director/Designee, on ensuring each resident has an operable lamp or other source of lighting that can be turned on at bedside by 2/28/23.
Maintenance Coordinator /Housekeepers will conduct an audit to ensure all occupied resident rooms have an operable source of lighting that can be turned on at bedside by 2/15/23.
.
Care Coordinators/Designee will make daily rounds on their neighborhoods and the Executive Director/Maintenance Coordinator will do weekly community walkthrough rounds to ensure all residents have operable lamp (plugged

101j7 Lighting/Operable Lamp (continued)

in)or other source of lighting that can be turned on at bedside. Any issues will be entered in the communities electronic TEL's system for timely replacement by Maintenance Coordinator/Designee 2/15/23 and ongoing. During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review results of daily/weekly walkthroughs to ensure each resident has an operable lamp or other source of lighting that can be turned on at bedside. Any issues not resolved timely will be reviewed and an action plan will be implemented.

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

Implemented [redacted] - 03/01/2023)

103e - Left Overs

6. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 1/10/23, at 10:25 a.m., there were unlabeled, undated stainless steel pans of applesauce and canned pineapple in the upright glass cooler in the main kitchen, and, at 10:31 a.m., there were 2 slices of unlabeled, undated ham in the small refrigerator under the counter.

On 1/10/23, at 11:03 a.m., there were 2 plates of unlabeled, undated leftover breakfast food in the 4th floor kitchenette refrigerator, one with bacon eggs, pancakes and sausage; the other with French toast, bacon, and eggs.

On 1/10/23 at 11:22 a.m., there were 2 plates of unlabeled, undated leftover breakfast food on the shelf in the SDCU kitchen.

Plan of Correction ***Accept ([redacted] - 02/10/2023)***

In regards to 2600.103e, The stainless pans of applesauce and canned pineapple in the upright glass cooler in the main kitchen, 2 slices of unlabeled undated ham in the small refrigerator were opened the day of inspection and dated and labeled at the time of inspection on 1/10/23 by the Dining Service Coordinator. The 2 plates of unlabeled , undated leftover breakfast food in the 4th floor kitchenette refrigerator as well as 2 plates of unlabeled , undated leftover breakfast food in the SDCU kitchen were disposed of at time of inspection on 1/10/23 by the Dining Service Coordinator.
The Dining Service Coordinator/Designee will re train all food service and direct care staff on proper labeling , dating and storage of all leftover food. The cooks and food service staff will be responsible for labeling ,dating and refrigerating all leftover food in the main kitchen immediately after each meal. The Lead Care Managers/Care managers will label ,date and refrigerate any leftover food in the ancillary kitchens immediately after each meal service by 2/28/23
The cooks will be responsible for ensuring all food is labeled and dated in the main kitchen, The Lead Care manager will be responsible for ensuring all leftover food in the ancillary kitchens are labeled,, dated and properly stored during each shift 2/28/23
The Care Coordinator/Designee will monitor ancillary kitchens daily during rounds. The Dining Service Coordinator/Designee will monitor main kitchen daily for compliance. The Dining Service Coordinator/ will check ancillary kitchens for compliance daily. The Executive Director will conduct routine quality assurance checks in the main kitchen and ancillary kitchens weekly to ensure all food is labeled dated and stored properly beginning

103e - Left Overs (continued)

2/15/23 and ongoing.
Results of daily and weekly walkthroughs will be reviewed monthly for the next 6 months at the communities QAPI meeting beginning 2/28/23. Any identified issues with labeling, dating and properly storing food with be discussed and action plan will be implemented.
In regards to 2600.103g, The unsealed packages of 8 frozen waffles and 7 eclairs in the side-by-side Arctic Air freezer in the main kitchen and unsealed packages of frozen waffles, soft tortillas, were disposed of and one 5lb. package of ground beef in the walk-in freezer in the main kitchen was sealed labeled, dated and secured at time of inspection on 1/10/23 by the Dining Service Coordinator.
The Dining Service Coordinator/Designee will re train all food service and direct care staff on sealing stored food in closed or sealed containers. The cooks and food service staff will be responsible for storing all food in closed or sealed containers in the main kitchen immediately after opening. The Lead Care Managers/Care managers be responsible for storing food in closed or sealed containers in the ancillary kitchens (3rd and 4th floor) immediately after opening by 2/28/23.
The cooks will be responsible for ensuring all food is stored in closed or sealed containers in the main kitchen, The Lead Care Manager will be responsible for ensuring all leftover food in the ancillary kitchens stored in closed or sealed containers during each shift 2/28/23 and ongoing.
The Care Coordinator/Designee will monitor ancillary kitchens daily during rounds. The Dining Service Coordinator/Designee will monitor main kitchen daily for compliance. The Dining Service Coordinator/Designee will check ancillary kitchens for compliance daily. The Executive Director will conduct routine quality assurance checks in the main kitchen and ancillary kitchens at weekly to ensure all food is labeled dated and stored properly beginning 2/15/23 and ongoing.
Results of daily and weekly walkthroughs will be reviewed monthly for the next 6 months at the communities QAPI meeting beginning 2/28/23. Any identified issues with properly storing food in closed or sealed containers with be discussed and action plan will be implemented.
In regards to regulation 2600.103i, the undated package of frozen waffles and the package of 7 eclairs in the side-by-side Artic Air freezer in the main kitchen, two undated 5lb. packages of pulled pork in the walk in refrigerator and undated package of waffles and soft tortillas in the walk-in freezer in the main kitchen were disposed of at the time of inspection on 10/10/23 by the Dining Service Coordinator . The frozen green and brown smoothie in the 3rd floor SDCU unit was also disposed of by the Dining Service Coordinator at the time of inspection (1/10/23).
The Dining Service Coordinator/Designee will re train all food service and direct care staff on proper labeling dating and storage of all leftover food. The cooks and food service staff will be responsible for labeling ,dating and refrigerating all leftover food in the main kitchen immediately after each meal. The Lead Care Managers/Care managers will label ,date and refrigerate any leftover food in the ancillary kitchen immediately after each meal service by 2/28/23
The cooks will be responsible for ensuring all food is labeled and dated in the main kitchen, The Lead Care manager will be responsible for ensuring all leftover food in the ancillary kitchens are labeled , dated and properly stored during each shift 2/28/23
The Care Coordinator/Designee will monitor ancillary kitchens daily during rounds. The Dining Service Coor/Designee will monitor main kitchen daily for compliance. The Dining Service Coor/ will check ancillary kitchens for compliance daily. The Executive Director will conduct routine quality assurance checks in the main kitchen and ancillary kitchens weekly to ensure all food is labeled dated and stored properly beginning 2/15/23 and ongoing.
Results of daily and weekly walkthroughs will be reviewed monthly for the next 6 months at the communities QAPI meeting beginning 2/28/23. Any identified issues with labeling, dating and properly storing food with be discussed and action plan will be implemented.
In regards to 2600.121a The 2 large, rolled-up bath towels blocking the egress from the home's emergency exit

103e - Left Overs (continued)

doors in the main dining rooms were removed at the time of inspection on 1/10/23 by the Maintenance Coordinator. Weather stripping was applied to the bottom of the door to prevents drafts. 2/8/23.
All staff will be provided re-training by the Executive Director/designee on ensuring stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed by 2/28/23
Maintenance Coordinator conducted and audit on 1/11/23 and confirmed that egress routes in the community were unobstructed.
Care Coordinators/Designee will make daily rounds on their neighborhoods and the Executive Director/Maintenance Coordinator will do weekly community walkthrough rounds to ensure all egress routes are unobstructed addressing and issues immediately. -2/15/23 and ongoing .
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review results of daily/weekly walk throughs reports monitor any instances of blocked egress routes and immediate action taken. An action plan will be developed if any items have not been addressed.
In regards to regulation 2600.132c the fire drill record for the drill conducted on 12/30/22 was updated at the time of inspection on 1/11/23 by the Maintenance Coordinator to include the amount of time it took for evacuation.
The Executive Director will retrain the Maintenance Coordinator and Leadership team on proper recording of written fire drill records to 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 personas participating, problems encountered and whether the fire alarm or smoke detector was operative by 2/28/23.
The Executive Director will review the written fire drill records monthly to ensure accuracy as evidence by signature on fire drill record beginning 2/28/23 and for the next 12 months.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 12 months, the committee will review monthly fire drill records for compliance. An action plan will be developed to address any variance to required information on the fire drill records.
In regards to 2600.183b. The tube of Calmoseptine ointment that was found to be unlocked, unattended, and accessible on resident #1 counter was removed and secured in the medication cart by Resident Care Director at the time of inspection on 1/11/23.
The Resident Care Director/Designee will provide retraining for all Wellness nurses, LPN and Medication Care managers on securing prescription medications, OTC medications, CAM and syringes in an area or container that is locked (medication cart) to include medications and syringes kept in the residents room 2/28/23
The Executive Director/Designee will provide retraining to all staff on storing medications in and area or container that is locked including medications and syringes kept in the residents room by 2/28/23.
The Resident Care director/ Designee is responsible for training new LPN/Medication Care Managers on properly securing medications upon hire 2/28/23 and ongoing.
LPN, Medication Care Managers , Wellness nurses will be responsible for securing prescription medications , OTC medications CAM and syringes in an area or container that is locked. 2/28/23 and ongoing.
All staff will be responsible for reporting any medications found to be unsecured to the Resident Care Director/Wellness nurse immediately. The Resident Care Director/Wellness nurse will ensure medications are immediately secured 2/28/23 and ongoing.
The Care Coordinators will check resident rooms for unsecured medications during daily rounds and Executive Director will do quality assurance checks during weekly rounds to ensure compliance and report any instances of medications not secured in the medication cart or secured in residents room if appropriate.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review compliance with medication storage and develop an action plan to address any instance of unsecured medication.
In regards to 2600.184a a change in direction sticker was applied to Residents #5's prescribed polyethylene glycol

103e Left Overs (continued)

powder and Resident [redacted] and prescribed [redacted] by the Resident Care Director at the time of inspection on 1/12/23.
The Resident Care Director will provide retraining for the Wellness Nurses, LPN ad Medication Care Managers on Storing prescription medications in their original container labeled with a pharmacy label that includes the residents name, the name of the medication, the date the prescription was issued, the prescribed dosage and instructions for administration and the name and tile of the prescriber. Staff will also be re trained on the triple check system ensuring medication label matches the medication administration record . Any variances are to be reported immediately to the Wellness Department for verification against physician orders. Medication change stickers will be applied to the medication label with any medication change until the pharmacy delivers the medication with the corrected label by 2/28/23 .
The Resident Care Director/Wellness nurse will be responsible for training new hires on ensuring residents medications are labeled per 2600.184a requirements 2/28/23 and ongoing.
The LPN Medication Care Managers/Medication Managers will conduct weekly cart audits to ensure medication labels match the medication administration record. The Resident Care Director will review weekly audits and correct any issues identified. The Resident Care Director will also conduct monthly cart audits to ensure all medications are labeled correctly beginning 2/28/23 and ongoing.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review medication cart audits and develop an action plan to address any identified issues.
In regards to 2600.224a Resident #2 pre admission screen form for Resident #2 who was admitted to the home on 2/28/22 however, the residents preadmission screening form was completed 1/17/20.
The Executive Director will re train the Resident Care Director and Wellness nurses by 2/28/23 on completing preadmission screening form within 30 days prior to admission and documented on the Departments preadmission screening form that the needs of the resident can be met by the services provided by home.
The Residence Care Director and Wellness nurses will audit all preadmission screen forms for existing residents to ensure the preadmission screen is completed within 30 days prior to admission on the preadmission screening form 2/28/23.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review the preadmission screening forms of all residents who moved into the community to ensure completion within 30 days prior to admission . If any issues are identified an action plan will be developed and implemented.
In regards to regulation number 2600.227g Resident #3 ,Resident #4 and Resident #1 with missing signatures . The community will schedule a support plan meeting with Resident/Responsible parties of the above residents to review the support plan and obtain required signatures for those who participate in the development of the support plan by 2/28/23.
The Executive Director will provide training to the residence Care Director, Wellness Nurses and Care Coordinators by 2/28/23 to review the expectation that individuals who participate in the development of the support plan shall sign and date the support plan.
The Care Coordinators will conduct an audit of all support plans to identify any instances where individuals who participated in the development of the support plan have not signed and dated the plan by 2/28/23. If any support plans are determined to have missing signatures, The Care Coordinator/Designee will schedule a support plan meeting to review the support plan and obtain signatures of the resident and responsible party as well as others who participated in the development of the plan. These meetings will be completed by 3/15/23.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review any support plans developed during the month to ensure individuals who participated in the development of the support plan have signed and dated the plan. If any missing signatures are identified an action plan will be developed and implemented.

103e Left Overs (continued)

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

Implemented [redacted] - 03/01/2023)

103g - Storing Food

7. Requirements

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

Description of Violation

On 1/10/23 at 10:28 a.m., there were unsealed packages of 8 frozen waffles and 7 eclairs in the side by side Arctic Air freezer in the main kitchen.

On 1/10/23 at 10:35 a.m., there were unsealed packages frozen waffles, soft tortillas, and one 5 lb. package of ground beef in the walk in freezer in the main kitchen.

Plan of Correction ***Accept [redacted] - 02/10/2023)***

In regards to 2600.103g, The unsealed packages of 8 frozen waffles and 7 eclairs in the side by side Arctic Air freezer in the main kitchen and unsealed packages of frozen waffles, soft tortillas, were disposed of and one 5lb. package of ground beef in the walk in freezer in the main kitchen was sealed labeled, dated and secured at time of inspection on 1/10/23 by the Dining Service Coordinator.
The Dining Service Coordinator/Designee will re train all food service and direct care staff on sealing stored food in closed or sealed containers. The cooks and food service staff will be responsible for storing all food in closed or sealed containers in the main kitchen immediately after opening. The Lead Care Managers/Care managers be responsible for storing food in closed or sealed containers in the ancillary kitchens (3rd and 4th floor) immediately after opening by 2/28/23.
The cooks will be responsible for ensuring all food is stored in closed or sealed containers in the main kitchen, The Lead Care Manager will be responsible for ensuring all leftover food in the ancillary kitchens stored in closed or sealed containers during each shift 2/28/23 and ongoing.
The Care Coordinator/Designee will monitor ancillary kitchens daily during rounds. The Dining Service Coordinator/Designee will monitor main kitchen daily for compliance. The Dining Service Coordinator/Designee will check ancillary kitchens for compliance daily. The Executive Director will conduct routine quality assurance checks in the main kitchen and ancillary kitchens at weekly to ensure all food is labeled dated and stored properly beginning 2/15/23 and ongoing.
Results of daily and weekly walkthroughs will be reviewed monthly for the next 6 months at the communities QAPI meeting beginning 2/28/23. Any identified issues with properly storing food in closed or sealed containers with be discussed and action plan will be implemented.

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

Implemented [redacted] - 03/01/2023)

103i - Outdated Food

8. Requirements

2600.

103i Outdated Food *(continued)*

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

Description of Violation

On 1/10/23, at 10:28 a.m., there was an undated package of 8 frozen waffles and a package of 7 eclairs in the side by side Arctic Air freezer in the main kitchen.

On 1/10/23, at 10:35 a.m., there were 2 undated 5 lb. packages of pulled pork in the walk in refrigerator and multiple undated packages of waffles and soft tortillas in the walk in freezer in the main kitchen.

On 1/10/23 at 11:21 a.m., there was an undated frozen green and brown substance in a glass jar in the freezer in the SDCU kitchenette.

Plan of Correction ***Accept [redacted] - 02/10/2023)***

In regards to regulation 2600.103i, the undated package of frozen waffles and the package of 7 eclairs in the side by side Artic Air freezer in the main kitchen, two undated 5lb. packages of pulled pork in the walk in refrigerator and undated package of waffles and soft tortillas in the walk in freezer in the main kitchen were disposed of at the time of inspection on 10/10/23 by the Dining Service Coordinator . The frozen green and brown smoothie in the 3rd floor SDCU unit was also disposed of by the Dining Service Coordinator at the time of inspection (1/10/23).
The Dining Service Coordinator/Designee will re train all food service and direct care staff on proper labeling dating and storage of all leftover food. The cooks and food service staff will be responsible for labeling ,dating and refrigerating all leftover food in the main kitchen immediately after each meal. The Lead Care Managers/Care managers will label ,date and refrigerate any leftover food in the ancillary kitchen immediately after each meal service by 2/28/23
The cooks will be responsible for ensuring all food is labeled and dated in the main kitchen, The Lead Care manager will be responsible for ensuring all leftover food in the ancillary kitchens are labeled , dated and properly stored during each shift 2/28/23
The Care Coordinator/Designee will monitor ancillary kitchens daily during rounds. The Dining Service Coor/Designee will monitor main kitchen daily for compliance. The Dining Service Coor/ will check ancillary kitchens for compliance daily. The Executive Director will conduct routine quality assurance checks in the main kitchen and ancillary kitchens weekly to ensure all food is labeled dated and stored properly beginning 2/15/23 and ongoing. Results of daily and weekly walkthroughs will be reviewed monthly for the next 6 months at the communities QAPI meeting beginning 2/28/23. Any identified issues with labeling, dating and properly storing food with be discussed and action plan will be implemented.

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

Implemented ([redacted] - 03/01/2023)

121a - Unobstructed Egress

9. 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 1/10/23, at 9:46 a.m., there were 2 large, rolled up bath towels blocking egress from the home's emergency exit

121a Unobstructed Egress (continued)

doors in the main dining room.

Plan of Correction ***Accept (- 02/10/2023)***

In regards to 2600.121a The 2 large, rolled up bath towels blocking the egress from the home's emergency exit doors in the main dining rooms were removed at the time of inspection on 1/10/23 by the Maintenance Coordinator. Weather stripping was applied to the bottom of the door to prevents drafts. 2/8/23.
All staff will be provided re training by the Executive Director/designee on ensuring stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed by 2/28/23
Maintenance Coordinator conducted and audit on 1/11/23 and confirmed that egress routes in the community were unobstructed.
Care Coordinators/Designee will make daily rounds on their neighborhoods and the Executive Director/Maintenance Coordinator will do weekly community walkthrough rounds to ensure all egress routes are unobstructed addressing and issues immediately. 2/15/23 and ongoing .
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review results of daily/weekly walk throughs reports monitor any instances of blocked egress routes and immediate action taken. An action plan will be developed if any items have not been addressed.

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

Implemented (- 03/01/2023)

132c - Fire Drill Records

10. 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 12/30/22 at 11:23 p.m. indicates the amount of time it took for a staff member to respond to the fire alarm and does not include the amount of time it took for evacuation.

Plan of Correction ***Accept (- 02/10/2023)***

In regards to regulation 2600.132c the fire drill record for the drill conducted on 12/30/22 was updated at the time of inspection on 1/11/23 by the Maintenance Coordinator to include the amount of time it took for evacuation.
The Executive Director will retrain the Maintenance Coordinator and Leadership team on proper recording of written fire drill records to 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 personas participating, problems encountered and whether the fire alarm or smoke detector was operative by 2/28/23.
The Executive Director will review the written fire drill records monthly to ensure accuracy as evidence by signature on fire drill record beginning 2/28/23 and for the next 12 months.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 12 months, the committee will review monthly fire drill records for compliance. An action plan will be developed to address any variance to required information on the fire drill records.

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

132c - Fire Drill Records *(continued)*

Implemented (- 03/01/2023)

183b - Meds and Syringes Locked

11. 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 , at there was a tube of ointment unlocked, unattended, and accessible on resident #1's bathroom counter.

Plan of Correction ***Accept (- 02/10/2023)***

In regards to 2600.183b. The tube of ointment that was found to be unlocked, unattended, and accessible on resident #1 counter was removed and secured in the medication cart by Resident Care Director at the time of inspection on 1/11/23.
The Resident Care Director/Designee will provide retraining for all Wellness nurses, LPN and Medication Care managers on securing prescription medications, OTC medications, CAM and syringes in an area or container that is locked (medication cart) to include medications and syringes kept in the residents room 2/28/23
The Executive Director/Designee will provide retraining to all staff on storing medications in and area or container that is locked including medications and syringes kept in the residents room by 2/28/23.
The Resident Care director/ Designee is responsible for training new LPN/Medication Care Managers on properly securing medications upon hire 2/28/23 and ongoing.
LPN, Medication Care Managers , Wellness nurses will be responsible for securing prescription medications , OTC medications CAM and syringes in an area or container that is locked. 2/28/23 and ongoing.
All staff will be responsible for reporting any medications found to be unsecured to the Resident Care Director/Wellness nurse immediately. The Resident Care Director/Wellness nurse will ensure medications are immediately secured 2/28/23 and ongoing.
The Care Coordinators will check resident rooms for unsecured medications during daily rounds and Executive Director will do quality assurance checks during weekly rounds to ensure compliance and report any instances of medications not secured in the medication cart or secured in residents room if appropriate.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review compliance with medication storage and develop an action plan to address any instance of unsecured medication.

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

Implemented (- 03/01/2023)

184a - Resident's Meds Labeled

12. 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.

184a - Resident's Meds Labeled *(continued)*

3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #5 is prescribed [redacted] by mouth as needed for constipation. Dissolve in 6-8 oz. liquid twice a day. However, the medication's pharmacy label indicates-17gms in 6-8 oz. of liquid by mouth twice daily.

Resident #6 is prescribed [redacted] in the morning, inject 4 units subq two times a day with meals, and inject per sliding scale, as follows: 70-140=0 units; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340= 5 units; 341-380= 6 units, greater than 380 call provider; subq with meals; however, the pharmacy label indicates-Inject 4 units subq 3 times a day with breakfast, lunch, and dinner.

Resident #6 is prescribed [redacted] in the morning; however, the pharmacy label indicates Inject 18 units subq every morning.

Plan of Correction ***Accept[redacted] - 02/10/2023)***

In regards to 2600.184a a change in direction sticker was applied to Residents #5's prescribed [redacted] powder and Resident #6 [redacted] and prescribed [redacted] by the Resident Care Director at the time of inspection on 1/12/23.

The Resident Care Director will provide retraining for the Wellness Nurses, LPN ad Medication Care Managers on Storing prescription medications in their original container labeled with a pharmacy label that includes the residents name, the name of the medication, the date the prescription was issued, the prescribed dosage and instructions for administration and the name and tile of the prescriber. Staff will also be re trained on the triple check system ensuring medication label matches the medication administration record . Any variances are to be reported immediately to the Wellness Department for verification against physician orders. Medication change stickers will be applied to the medication label with any medication change until the pharmacy delivers the medication with the corrected label by 2/28/23 .

The Resident Care Director/Wellness nurse will be responsible for training new hires on ensuring residents medications are labeled per 2600.184a requirements 2/28/23 and ongoing.

The LPN Medication Care Managers/Medication Managers will conduct weekly cart audits to ensure medication labels match the medication administration record. The Resident Care Director will review weekly audits and correct any issues identified. The Resident Care Director will also conduct monthly cart audits to ensure all medications are labeled correctly beginning 2/28/23 and ongoing.

During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review medication cart audits and develop an action plan to address any identified issues.

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

Implemented[redacted] - 03/01/2023)

224a - Preadmission Screen Form

13. Requirements

2600.

224a Preadmission Screen Form *(continued)*

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 #2 was admitted to the home on [redacted]; however, the resident's preadmission screening form was completed on [redacted]

Plan of Correction ***Accept [redacted] - 02/10/2023)***

In regards to 2600.224a Resident #2 pre admission screen form for Resident #2 who was admitted to the home on 2/28/22 however, the residents preadmission screening form was completed [redacted].
The Executive Director will re train the Resident Care Director and Wellness nurses by 2/28/23 on completing preadmission screening form within 30 days prior to admission and documented on the Departments preadmission screening form that the needs of the resident can be met by the services provided by home.
The Residence Care Director and Wellness nurses will audit all preadmission screen forms for existing residents to ensure the preadmission screen is completed within 30 days prior to admission on the preadmission screening form 2/28/23.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review the preadmission screening forms of all residents who moved into the community to ensure completion within 30 days prior to admission . If any issues are identified an action plan will be developed and implemented.

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

Implemented ([redacted] - 03/01/2023)

227g -Support Plan Signatures

14. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The support plan for resident #1, dated [redacted], is not signed by anyone.

The support plan for resident #3, dated [redacted] was not signed by the resident until [redacted]

The support plan for resident #4, dated [redacted], is not signed by anyone.

Plan of Correction ***Accept ([redacted] - 02/10/2023)***

In regards to regulation number 2600.227g Resident #3 ,Resident #4 and Resident #1 with missing signatures . The community will schedule a support plan meeting with Resident/Responsible parties of the above residents to review the support plan and obtain required signatures for those who participate in the development of the support plan by 2/28/23.
The Executive Director will provide training to the residence Care Director, Wellness Nurses and Care Coordinators by 2/28/23 to review the expectation that individuals who participate in the development of the support plan shall sign and date the support plan.
The Care Coordinators will conduct an audit of all support plans to identify any instances where individuals who

227g -Support Plan Signatures (continued)

participated in the development of the support plan have not signed and dated the plan by 2/28/23. If any support plans are determined to have missing signatures, The Care Coordinator/Designee will schedule a support plan meeting to review the support plan and obtain signatures of the resident and responsible party as well as others who participated in the development of the plan. These meetings will be completed by 3/15/23.
During the monthly Quality Management (QAPI) meeting 2/28/23 and for the next 6 months, the committee will review any support plans developed during the month to ensure individuals who participated in the development of the support plan have signed and dated the plan. If any missing signatures are identified an action plan will be developed and implemented.

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

Implemented [redacted] - 03/01/2023)