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

March 15, 2023

[redacted], OFFICE MANAGER
JAI JALARAM CARE LP
[redacted]

RE: FAITHFUL LIVING
2015 NORTH READING ROAD
DENVER, PA, 17517
LICENSE/COC#: 32258

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *FAITHFUL LIVING* **License #**: *32258* **License Expiration**: *03/21/2024*

Address: *2015 NORTH READING ROAD, DENVER, PA 17517*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *JAI JALARAM CARE LP*

Address: *2015 NORTH READING ROAD, DENVER, PA, 17517*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/03/1985* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *74* **Waking Staff**: *56*

Inspection Information

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

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

Inspection Dates and Department Representative

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

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *14* **Are 60 Years of Age or Older**: *66*

Diagnosed with Mental Illness: *19* **Diagnosed with Intellectual Disability**: *5*

Have Mobility Need: *1* **Have Physical Disability**: *1*

Inspections / Reviews

01/11/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/04/2023*

02/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/06/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/21/2023*

Inspections / Reviews *(continued)*

02/27/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/06/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/06/2023*

03/15/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/06/2023*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

During the inspection of the facility on 1/12/23, there was no carbon monoxide detector at or in close proximity of the two gas furnaces in the center basement area. Further, the laundry room has a gas-fired dryer but there was no Carbon Monoxide detector in close proximity to the appliance as required by the Care Facility Carbon Monoxide Alarms Standards Act.

Repeat Violation - 08/18/21

Plan of Correction ***Accept (- 02/27/2023)***

1. Carbon Monoxide Detectors were purchased and installed by maintenance upon notification on 1/12/23. Maintenance Staff were re-educated on the Care Facility Carbon Monoxide Alarms Standards Act on 1/12/23 by Administrator. Maintenance staff will perform monthly checks to ensure that detectors are performing correctly and yearly checks for battery changes. The Carbon Monoxide detectors will be marked with the date of last battery change. Maintenance Staff will be providing training for all staff on the Care Facility Carbon Monoxide Alarms Standards Act at the next staff meeting on 3/24/23.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented (- 03/06/2023)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated , for Resident #1 was not signed by the resident.

The resident-home contract, dated , for Resident #2 was not signed by the resident.

Plan of Correction ***Accept (- 02/27/2023)***

2. Administrator reviewed contract with resident 1 on and obtained signatures to contract. Resident 2 was discharged to the hospital on and was admitted to a skilled nursing facility so signatures were unable to be obtained. Re-training on contract requirements will be completed by Administrator with all business office staff who assist with contracts on at management meeting. Documentation of training will be kept in Administrator office. Beginning on Administrator will review 20% of all existing contracts monthly for required signatures until complete, and will review the contract for every new resident for required signatures at time of admission.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented (- 03/06/2023)

85e - Trash Outside Home

3. 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 1/11/23, the sliding side door of the large dumpster inside the white vinyl fencing area used by the home was open showing a large amount of trash inside the dumpster which is visible from across the parking lot.

Plan of Correction ***Accept [redacted] - 02/27/2023)***

3. Item was corrected during inspection by Administrator on 1/11/23. All staff to be re-educated on 2600.85e by administrator on 2/22/23. Starting on 2/15/23, Kitchen Manager will perform a daily walk through of dumpster area to verify that dumpster remains closed. This walk through will be performed twice daily, upon arrival and before leaving premises at end of shift for 30 days, then 1 time a day for 3 months. Any findings will be corrected immediately and reported at the next Quality Management Meeting on 3/15/23.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented ([redacted] - 03/06/2023)

89b - Hot Water Temperature

4. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 1/12/23 at 10:45am, the hot water at the kitchenette sink in Resident Room 160, occupied by Residents #3 and #4, measured 147 degrees Fahrenheit.

On 1/12/23 at 11:20am, the hot water in the bathroom in Resident Room 112, occupied by two residents, measured 124 degrees Fahrenheit.

On 1/12/23 at 11:14am, the hot water at the kitchenette in the library of the "west wing" of the home, accessible to residents, measured 123.8 degrees Fahrenheit.

Repeat Violation - 08/18/21

Plan of Correction ***Accept [redacted] - 02/27/2023)***

4. Resident number 3 and 4 were immediately moved from that part of the building on 1/14/23. Water temperatures were decreased upon notification on 1/12/23 by Maintenance Director. From 1/12/23 Maintenance Director has been completing daily water temperature checks to ensure that water temps remain within regulatory range. Daily checks will continue to ensure that water temp does not exceed 120 degrees. If water temperature is found at any time to exceed 120 degrees, Administrator to be notified immediately and temperature will be adjusted. Daily checks will be reviewed by Administrator on the first of each month for the month prior.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented [redacted] - 03/06/2023)

91 - Telephone Numbers

5. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

Upon inspection on 1/12/23, there are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in Resident Room 112.

Upon inspection on 1/12/23, the landline telephone in bedroom 205, occupied by Resident #5, has no emergency telephone numbers posted on or near the telephone.

Upon inspection on 1/12/23, the landline telephone in the meeting/training room has emergency service numbers posted on or near the telephone.

Plan of Correction ***Accept (- 02/27/2023)***

5. Corrected upon notification on 1/12/23 by Business Office Manager and Administrator in room 112, 205, and the training room. Beginning on 2/15/23, Administrator began replacing all current emergency number stickers with a laminated copy of emergency numbers attached to the phone cord via zip tie to ensure that the numbers do not fade, are accurate, and remain with phone. Replacements will be completed for all phones in building by 2/17/23. Beginning on 2/17/23, housekeeping will complete weekly audit of emergency number placement for 3 months, and then monthly thereafter as they will be solely responsible for auditing emergency number placement. Housekeeping was re-educated on job duties by Business Office Manager on 1/12/23 as well as the emergency number regulatory requirements.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented - 03/06/2023)

92 - Windows

6. 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

Resident Room , occupied by Resident #5, has two windows that are in poor repair as evidenced by a missing pane of glass that has been replaced with a clear piece of plastic/plexiglass secured by tape to the wooden frame. Another window located in room has a pane which has several cracks in the glass.

Plan of Correction ***Accept (- 02/27/2023)***

6. All 3 windowpanes were replaced with glass on 1/14/23 by Maintenance Director. Maintenance Director to complete weekly building walk throughs which include the checking of all windows and screens to ensure that they are in proper working condition. Any findings will be immediately reported to Administrator. Maintenance director to complete training with all staff by 3/10/23 to review at Quality Management Meeting on 3/15/23. This training will cover the regulation regarding windows and screens, as well as the importance of reporting repairs that are needed

92 Windows (continued)

using the maintenance request form located outside of the maintenance office. Documentation of this training will be kept in the Administrators office.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented [redacted] - 03/06/2023)

102i - Soap Dispenser

7. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was an unlabeled used bar of white soap in the shower area in the bathroom of shared resident room #125.

There was an unlabeled used bar of blue soap in the bathtub and a bar of Dove soap at the sink in the bathroom of shared resident room #115.

Plan of Correction ***Accept ([redacted] - 02/27/2023)***

7. Corrected upon notification on 1/12/23 by Administrator in room 115 and 125. Both residents were re educated verbally by Administrator on 1/14/23 on the importance of labeling soap in a shared room. All staff to be educated by Administrator on 2/22/23 that bar soap in double occupancy rooms will need to be in soap caddies and labeled with the resident's name of whom the soap belongs to. Documentation of such training to be kept in administrator office. Beginning on 2/22/23 third shift care staff will be responsible for performing daily audits on shared bathrooms to ensure that all resident items are labeled and in the proper storage containers for each resident. This task has been added to daily task sheets, which will be turned in to the med office and reviewed by Administrator daily to ensure compliance.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented [redacted] - 03/06/2023)

107c - Food/Water 3 Day Supply

8. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 1/12/23, the home served 72 residents, requiring at least 216 gallons of emergency drinking water. However, the home had only 199 gallons of emergency drinking water on site. The home does not have an emergency water contract with a local bottled water supplier.

107c - Food/Water 3 Day Supply *(continued)*

Plan of Correction ***Accept (- 02/27/2023)***

8. Item was corrected upon inspection on 1/12/23 by Kitchen Manager who obtained amount of gallons needed. Contract was obtained with Markets on 2/17/2023 to now be the emergency water supplier. They will supply 3 gallons of water per resident per day in the event of any emergency. Kitchen Manager was educated on the importance of the emergency water regulation by Administrator on 1/12/23.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented - 03/06/2023)

125a - Combustible Storage

9. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

There is a wooden curio cabinet outside of room 157 which is readily accessible to anyone. A partially full blue 14.1 oz cylinder bottle of propane and a 3/4 full 16oz spray can of Gumout Carb + Choke Cleaner were found located in this cabinet. Both of these items are unlocked and accessible and marked as "extremely flammable." The Propane is labeled "fire/explosion hazard" while the carb cleaner states, "exposure to heat may cause the can to burst".

There was also a 12 oz plastic bottle of Ronsonol lighter fuel belonging to Resident #5 that the resident keeps in their room. The bottle is labeled as extremely flammable.

Plan of Correction ***Accept - 02/27/2023)***

9. All flammable items were removed from the home by Administrator upon notification on 1/11/23. All staff will be trained on combustible materials and regulation 2600.125a at the all-staff meeting occurring on 2/22/23. Resident #5 was educated at time of inspection by Administrator on the appropriate items that are allowed in the home, and on the dangers of flammable materials. Resident #5 was also educated that lighter fluid is not an item permissible to have in the home. Beginning on 2/15/23, Administrator and Business Office Manager will perform daily room checks of 6 rooms, therefore checking all rooms in the PC unit on a weekly basis to ensure there are no flammable materials present. If flammable items are found during room checks, they will be removed from the home immediately and education will be performed with the resident of the room where the item was found. These audits will continue weekly for 3 months, then biweekly for 3 months to ensure continued compliance. In addition, all new residents moving into the home will be educated by the administrator upon admission to the home on the dangers of combustible and flammable materials and that they are not permitted inside the home.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented - 03/06/2023)

141a 1-10 Medical Evaluation Information

10. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The medical evaluation dated [redacted] for Resident #6 did not include the type of evaluation, height, special health or dietary needs, and immunization history.

The medical evaluation dated [redacted] for Resident #1 did not include the resident's weight.

The medical evaluation dated [redacted] for Resident #7 did not include body positioning/movement, health status or cognitive functioning.

Plan of Correction ***Accept ([redacted] - 02/27/2023)***

Resident # 1, #6, #7 the person in place at the time of their admissions are no longer employed with the company.

Wellness Coordinator/Compliance Officer was put in place to oversee this process, Wellness Coordinator/Compliance Officer will educate the administrative staff on 2/22/2023 regarding the importance of having the form completed in its entirety and will be reviewed at the next Quality Meeting on 3/15/2023.

Wellness Coordinator/Compliance Officer will a conduct an audit starting 3/1/2023 for 90 days then thereafter for new admissions and annual Medical Evaluations on a continual basis.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented ([redacted] - 03/07/2023)

141b1 - Annual Medical Evaluation

11. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The annual medical evaluation dated [redacted] for Resident #2 was not complete, it did not include the resident's weight and temperature.

141b1 Annual Medical Evaluation (continued)

The annual medical evaluation dated [redacted] for Resident #8 was not complete, it did not include the resident's temperature.

The annual medical evaluation dated [redacted] for Resident #9 was not complete, it did not include the resident's temperature.

The annual medical evaluation dated [redacted] for Resident #7 was not complete, it did not include the resident's temperature.

The annual medical evaluation dated [redacted] for Resident #10 was not complete, it did not include the resident's temperature or immunization history.

Plan of Correction ***Accept ([redacted] - 02/27/2023)***

Resident 2, 7, 8, 9, 10 Administrator reached out to the residents CRNP at Wellspan Health regarding the importance of all boxes on the DME need to be complete, CRNP will come to the facility on [redacted] to complete.

Wellness Coordinator/Compliance Officer was put in place to oversee this process, Wellness Coordinator/Compliance Officer will educate the administrative staff on 2/22/2023 regarding the importance of having the form completed in its entirety and will be reviewed at the next Quality Meeting on 3/15/2023.
Wellness Coordinator/Compliance Officer will a conduct an audit starting 3/1/2023 for 90 days then thereafter for new admissions and annual Medical Evaluations on a continual basis.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented ([redacted] - 03/07/2023)

144c1 - Smoking Area Guidelines

12. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home permits smoking in the designated smoking areas at the two ends of the home outside. There are signs posted outside the main entrance stating "No Smoking In This Area". However, upon approach to the entrance the home on 1/11/23, inspectors observe approximately ten (10) cigarette butts, most have yellow filters, several are white filters located in the mulch next to the front door. In addition, there are multiple cigarette butts on the asphalt under the portico.

In addition, on 1/12/23, upon approach to the bedroom of Resident #5, there was an odor of cigarette smoke. The inspector viewed a plastic cup with water and a cigarette butt in it in the resident room, and during the interview, Resident #5 admits to smoking in their room.

144c1 - Smoking Area Guidelines (continued)

Repeat Violation - 08/18/21

Plan of Correction ***Accept [redacted] - 02/27/2023)***

12. Maintenance Director removed all cigarette butts from the property on 1/13/23 following inspection. Resident #5 was re-educated on the smoking policy in the home again on 1/12/23. This was a final notice for the resident. Starting immediately on 1/13/23, resident #5 is on daily room checks by the Administrator to ensure that he is not smoking in his apartment. Continued non-compliance will result in a 30 day notice to vacate. Maintenance Director to continue with daily rounds of the premises to ensure no cigarette butts are present. If Cigarette Butts are found, the items will be cleared immediately and Administrator will be notified. Maintenance Director audits will be ongoing to ensure continued compliance. All staff will be re-educated on the importance of 2600.144c at the all staff meeting on 2/22/23 by the Administrator. Documentation of this training will be kept in the Administrator office.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented ([redacted] 03/07/2023)

183b - Meds and Syringes Locked

13. 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 [redacted], there was a bottle of low-dose [redacted] and [redacted] peppermint-flavored [redacted] found the kitchen counter in the bedroom of Resident #11. This resident is not assessed to be able to self-administer any medications as per his/her current DME, RASP, and interview of staff.

On [redacted], a tube of [redacted] and a bottle of [redacted] were found in the shared room of Resident #12. Resident #12 is assessed to self-administer these medications. However, the resident has a roommate and does not have a lockbox or any other area or container that locks in order to safely store these medications in her room.

On [redacted], a tube of [redacted], a bottle of [redacted] and a tub of [redacted] were found in the shared room of Resident #1. Resident #1 is assessed to self-administer these medications. However, the resident has a roommate and admitted to not keeping these items in a lockbox or any other area or container that locks in order to safely store these medications in her room.

Plan of Correction ***Accept ([redacted] - 02/27/2023)***

13. Resident 11 – all OTC items were removed upon notification on 1/12/23 by Administrator. Upon removal of the items, resident was re-educated on proper medication storage. This resident is now a Personal Care resident and therefore all medications will need a corresponding order from a CRNP or PCP. Family was also educated by Administrator that they are not able to provide OTC medications directly to the resident.
Resident 12 – Resident was re-educated on 1/12/23 by Administrator on proper medication storage as well as proper self-administration policies, specifically in a shared living space. Resident has been made aware through the re-education that all medications must be stored in [redacted] locked box when not in use for safety.
For all residents listed above, in conjunction with room checks detailed in item number 9, Administrator and Business Office Manager will perform daily room checks of 6 rooms, therefore checking all rooms on Personal Care unit on a

183b Meds and Syringes Locked (continued)

weekly basis to ensure there are no medications present. These checks are to begin on 2/15/23. If medications are found during room checks, they will be removed from the area immediately and education will be performed with the resident of the room where the item was found. Residents have been made aware by Administrator on 1/12/23 that if medications are found not properly stored further action will follow such as contacting Primary Care Physician for re evaluation with the possibility of no longer being able to self administer medications due to unsafe practices. These audits will continue weekly for 3 months, then biweekly for 3 months to ensure continued compliance. All staff to be educated by Administrator on safe practices of Medication Self Administration at all staff meeting on 2/22/23.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented [redacted] - 03/07/2023)

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

On [redacted], Resident #10's glucometer was not calibrated to the correct time. The actual time was [redacted] and the glucometer read [redacted].
On [redacted], Resident #13's glucometer was not calibrated to the correct time. The actual time was [redacted] and the glucometer read [redacted].
On [redacted] Resident #14's glucometer was not calibrated to the correct date and time. The actual time was [redacted] and the glucometer read [redacted] at [redacted]
On [redacted], Resident #15's glucometer was not calibrated to the correct date and time. The actual time was [redacted] pm and the glucometer read [redacted] at [redacted]

On [redacted], Resident #10's glucometer read [redacted] at [redacted], however the number documented in the Medication Administration Record (MAR) was [redacted]
On [redacted] Resident #13's glucometer read [redacted] at [redacted], however the number documented in the Medication Administration Record (MAR) was [redacted]
On [redacted], Resident #13's glucometer read [redacted] at [redacted], however the number documented in the Medication Administration Record (MAR) was [redacted]
On [redacted], Resident #13's glucometer read [redacted] at [redacted], however the number documented in the Medication Administration Record (MAR) was [redacted]
On [redacted], Resident #13's glucometer read [redacted] at [redacted] pm, however the number documented in the Medication Administration Record (MAR) was [redacted]
On [redacted], Resident #15's glucometer read [redacted] at [redacted] pm, however the number documented in the Medication Administration Record (MAR) was [redacted]
On [redacted], Resident #15's glucometer read [redacted] at [redacted], however the number documented in the Medication Administration Record (MAR) was [redacted].
On [redacted], Resident #15's glucometer read [redacted] at [redacted], however the number documented in the Medication Administration Record (MAR) was 98.
On [redacted], Resident #14's glucometer read [redacted] at [redacted], however the number documented in the Medication Administration Record (MAR) was [redacted]

185a - Implement Storage Procedures (continued)

On [redacted], Resident #14's glucometer read[redacted] at[redacted], however the number documented in the Medication Administration Record (MAR) was [redacted]

Plan of Correction ***Accept [redacted] - 02/27/2023)***

14. All glucometers were calibrated to the correct date and time on 1/18/2023 by Residential Services Assistant. Clinical staff were re-educated on accurate documentation as well as glucometer usage and safety on 1/13/23 by Administrator. Effective 1/13/23, Residential Services Assistant will randomly select 3 glucometers to audit every week for 4 weeks, and monthly thereafter. These audits will be ongoing to ensure continued compliance with the regulation. Findings of these audits will be brought to and discussed at Quality Management meetings beginning on 3/15/23.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented [redacted] - 03/07/2023)

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 #1 was prescribed [redacted] twice daily as needed for ten days on [redacted], as well as [redacted] capsules before dental appointment on [redacted]. These medications were never discontinued. On [redacted] medications were not available in the home.

Resident #12 was prescribed [redacted] as needed for pain. On[redacted] this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 02/27/2023)***

Resident #1 [redacted] was removed the MAR on[redacted] and the [redacted] was removed from the MAR on 1/13/2023.

Resident #12 had a discontinue order sent 10/6/2022 and it was signed by the CRNP on 10/7/2022. Discontinue order was faxed to pharmacy x2 and removed from MAR on 12/9/2022.

Resident Service Assistant will educate on having all medications and on MAR available for All residents at all times on 2/22/2023. Resident Service Assistant will review Medication Carts weekly starting 3/1/2023 for 20% of residents for all medications for 4 weeks until completed. Then a weekly audit will occur for 5% of residents on a continual basis.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented [redacted] - 03/07/2023)

227d - Support Plan Medical/Dental

16. 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

The medical evaluation and assessment for Resident #8, indicates the resident has a need for diabetes management. The resident's support plan does not document how this need will be met.

Repeat Violation - 08/18/21

Plan of Correction ***Accept [redacted] - 02/27/2023)***

16. Home obtained an order for PRN blood glucose checks on 1/27/23, as well as the supplies needed to perform the checks to monitor for signs and symptoms of Hypoglycemia and Hyperglycemia. The Resident's support plan was updated to reflect this change on 1/27/2023 by Wellness Coordinator/Compliance Officer. Beginning on 3/1/23, Administrator and Auditor to audit 25% of support plans each month to ensure that they encapsulate all necessary information for each resident. These audits will continue until all Support Plans have been audited. After initial audit has been completed, Administrator/Auditor to randomly select 5 Support Plans to be audited each month to ensure ongoing compliance. Findings will be discussed at Quality Management Meetings beginning on 3/15/23.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented ([redacted] - 03/07/2023)

227e - Self Administer Medication

17. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident #1's assessment, dated [redacted] does not address the Resident's ability to self-administer medications, nor give details regarding assistance necessary for their safe administration.

Resident #7's assessment, dated [redacted], does not address the Resident's ability to self-administer medications, specifically Albuterol, nor give details regarding assistance necessary for the safe administration and storage.

Plan of Correction ***Accept [redacted] - 02/27/2023)***

Resident #1 DME completed on [redacted] and support plan was updated [redacted].

Resident #7 support plan was updated [redacted]

Wellness Coordinator/Compliance Officer will audit 20% of all resident support plans weekly starting 3/1/2023 until completed and any new admissions and thereafter 5% on a monthly basis continuously.

227e - Self Administer Medication (continued)

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented (- 03/07/2023)

227g -Support Plan Signatures

18. Requirements

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

Description of Violation

Resident #7 participated in the development of his/her support plan on . However, the assessor from the home did not sign the support plan.

Plan of Correction ***Accept - 02/27/2023)***

18. Resident 7's support plan was unable to corrected. Training on Support Plans and required components will be completed at all staff meeting on 2/22/23 and will be conducted by Administrator. This training will be for all staff, but specifically clinical staff and those involved in creating support plans. In conjunction with the audits mentioned in items 16 and 17 pertaining to Support Plans, Administrator and Auditor will also be auditing for required signatures on the Support Plan. The audit schedule will be as follows: Beginning on 2/1/23, Administrator and Auditor to audit 25% of support plans each month to ensure that they encapsulate all necessary information and signatures for each resident. These audits will continue until all Support Plans have been audited. After initial audit has been completed, Administrator/Auditor to randomly select 5 Support Plans to be audited each month to ensure ongoing compliance. Findings will be discussed at Quality Management Meetings beginning on 3/15/23. For new admissions, all new Support Plans will be completed by Auditor and turned into Administrator for second review.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented - 03/07/2023)