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

March 2, 2023

[redacted]
STONERIDGE RETIREMENT LIVING
450 EAST LINCOLN AVENUE
MYERSTOWN,, PA, 17067

RE: STONERIDGE POPLAR RUN
450 EAST LINCOLN AVENUE
MYERSTOWN,, PA, 17067
LICENSE/COC#: 30899

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/24/2023 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: *STONERIDGE POPLAR RUN* **License #**: *30899* **License Expiration**: *09/11/2023*

Address: *450 EAST LINCOLN AVENUE, MYERSTOWN,, PA 17067*

County: *LEBANON* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *STONERIDGE RETIREMENT LIVING*

Address: *450 EAST LINCOLN AVENUE, MYERSTOWN,, PA, 17067*

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

Certificate(s) of Occupancy

Type: *C-1* **Date**: *11/04/1993* **Issued By**: *Department of Health*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *24* **Waking Staff**: *18*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *01/24/2023*

Inspection Dates and Department Representative

01/24/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *24*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *24*

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

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

Inspections / Reviews

01/24/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/05/2023*

02/06/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/02/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/10/2023*

Inspections / Reviews *(continued)*

02/10/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/02/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/02/2023*

03/02/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/02/2023*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] at approximately [redacted], an incident of alleged abuse from staff to resident occurred. This incident was observed by Staff Member A. However, the Act 13 Mandatory Abuse form was not completed and submitted to AAA until [redacted].

Plan of Correction ***Directed (CR - 02/10/2023)***

> On 1/30/23, Executive Director reviewed and re-trained on regulation 2600 15a-Resident Abuse Reporting.

> On 1/30/23 A training plan was created by the Executive Director covering the following items:
- Abuse Reporting Covered by Law 2600 15(a), 15(b), 15(c), and 15(d).
- The Mandatory Abuse Report Form
- "Abuse and Abuse Reporting" in "Regulatory Issues and Frequently Occurring Situations.
- Suspected Resident Abuse reporting and Investigation Requirements Tree

> All Direct Care staff to be retrained by the Director of Clinical Education, utilizing the attached documents and the Personal Care Homes Record of Training Form by 2/28/23. All incident reports and reportable incidents will be reviewed daily by Executive Director or Designee. The Executive Director or Designee will be responsible to report any suspected abuse incidents within 48 hours of incident.

>Reportable incidents that occurred will be reviewed during quarterly QA meeting to ensure all appropriate actions have taken place. The next scheduled QA will be held on April 12th.

(Directed)

- *Beginning on 2/10/2023 all incident reports and reportable incidents will be reviewed daily by Executive Director or Designee. The Executive Director or Designee will be responsible to report any suspected abuse incidents within 48 hours of incident.*

Directed Completion Date: *02/28/2023*

Implemented (CR - 03/02/2023)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] at approximately [redacted], an incident of alleged abuse from staff to resident occurred. This incident was observed by Staff Member A. The home did not report this incident to the Department until 6:00 PM on [redacted].

16c - Written Incident Report *(continued)*

Plan of Correction ***Directed (CR - 02/10/2023)***

> On 1/30/23, Executive Director reviewed and re-trained on regulation 2600 16c-Incident Reporting.

> On 1/30/23 A training plan was created by the Executive Director covering the following items:
- *Incident Reporting 2600 16(c)*
- *Appendix A: Reportable Incidents*
- *Appendix B: Requirements and Best Practices for Reportable Incidents*

> All Direct Care staff to be retrained on incident reporting by the Director of Clinical Education by 2/28/23. All incident reports and reportable incidents will be reviewed daily by Executive Director or Designee. The Executive Director or Designee will be responsible to report any suspected abuse incidents within 48 hours of incident and incident reports within 24 hours.

>Reportable incidents that occurred will be reviewed during quarterly QA meeting to ensure all appropriate actions have taken place. The next scheduled QA will be held on April 12th.

(Directed)
Beginning on 2/10/2023 all incident reports and reportable incidents will be reviewed daily by Executive Director or Designee. The Executive Director or Designee will be responsible to report any suspected abuse incidents within 48 hours of incident.

Directed Completion Date: *02/28/2023*

Implemented (CR - 03/02/2023)

25b - Contract Signatures

3. 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 [redacted], for Resident #1 was not signed by the resident.

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

> On January 30th, 2023, Executive Director sat with resident 1, and resident signed off on any missing lines that required a resident signature. Please see attached document for completed signatures.

> All current resident contracts shall be reviewed starting on 2/6/23 by Executive Director or Designee completed by 2/28/23. Executive Director to assure that all contracts are signed off appropriately and secure any outstanding signatures by 2/28/23.

25b - Contract Signatures (continued)

> Moving forward starting on 2/1/23 all new resident move-ins and following resident contract signing, PCHA will review the residency agreement within 72 hours following admission to assure all required signatures are completed.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Implemented (CR - 03/02/2023)

26a - Quality Management Plan

4. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home has not implemented its quality management plan as it has not conducted a quality management review since December 2021.

Plan of Correction ***Directed (CR - 02/10/2023)***

> The Quality Management Plan Meeting Agenda was created on 1/30/23. The first meeting of 2023 was held on 2/1/23 and covered all incident reporting, resident council meetings, complaints, staff training, and licensing violations for all incidents and meetings occurring during fiscal year during all of 2022. The next meeting is scheduled in April to cover any items during the months of January, February and March of 2023.

> Please see the attached, new policy and agenda, and the completed agenda for the most recent Quality Management Plan Review held on Wednesday 2/1/23 and supporting documentation.

> The Quality Management Plan Policy has been changed to be conducted on a quarterly basis. The meeting will be held on the following months covering the preceding quarter. #1: January to cover quarter 4 (reviewing the months of months October, November and December), #2: April to cover quarter 1 (covering the months of January, February, and March), #3: July to cover quarter 2 (covering the months of April, May, and June), and #4: October to cover quarter 3 (covering the months of July, August, and September).

> On 2/1/23 a quality management meeting was held the meeting was led by the Executive Director, next meeting is scheduled for 12th and will be led by the Executive Director or Designee or Designee, Executive Director or Designee will be responsible to prepare the agenda, review the documentation and lead the meetings, and follow up on areas to evaluate and improve.

(Directed)

- *The Quality Management Plan Policy was reviewed and updated on 2/3/2023 by the Interim Executive Director.*
- *On 2/1/23 a quality management meeting was held the meeting was led by the Executive Director, next meeting is scheduled for April 12th and will be led by the Executive Director or Designee or Designee, Executive Director or Designee will be responsible to prepare the agenda, review the documentation and lead the meetings, and follow up on areas to evaluate and improve.*

26a - Quality Management Plan *(continued)*

Directed Completion Date: *02/17/2023*

Implemented (CR - 03/02/2023)

41e - Signed Statement

5. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

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

> Resident #1's resident rights record was corrected on [redacted] by the Executive Director.

> On [redacted], Executive Director sat with resident 1 to review a copy of the resident rights and complaint procedures. Please see attached document for completed signatures.

> All current resident contracts shall be audited and reviewed by Administrator or Designee by 2/17/23. PCHA to assure that all resident rights and complaint procedures have been reviewed with resident and are acknowledged appropriately.

> Moving forward starting on 2/8/23 following resident contract signings, Executive Director or Designee will review the resident rights and complaint procedure forms to assure all required signatures have been reviewed with resident and are acknowledged by signature.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented (CR - 03/02/2023)

141a - Medical Evaluation

6. 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 #2, admitted on [redacted], did not have a medical evaluation completed until [redacted].

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

> Resident 2 was admitted on [redacted] and the medical evaluation was not completed until [redacted].

>Resident 2 medical evaluation is attached, and all personal care resident medical evaluations will be audited

141a - Medical Evaluation (continued)

monthly starting in February of 2023 for accuracy and completion by Administrator, or Designee by 2/17/23.

< Starting February 6, 2023, all new residents and residents with significant changes DME Medical Evaluation Forms will be reviewed for accuracy and completion by the Administrator or Designee.

> On 2/2/23 all DME Medical Evaluation forms for current residents were audited by LPN.

> From the audited information any residents needing updated DME forms will be completed prior to 2/17/23.

> Moving forward a random monthly audit will begin on 2/6/23 by Executive Director or Designee. Please see attached audit worksheet. To ensure compliance, DME's for new admissions will be reviewed prior to 30 days following admission date. to ensure a DME is completed 60 days prior to admission or within 30 days after admission.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented (CR - 03/02/2023)

141b1 - Annual Medical Evaluation

7. Requirements

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

Description of Violation

On 1/24/2023, Resident #3's most recent medical evaluation was completed on [redacted].

Plan of Correction ***Directed (CR - 02/10/2023)***

> Resident #3's previous medical evaluation was completed on [redacted]

> Resident #2's attached updated medical evaluation was completed and signed off on [redacted]

> All resident medical evaluations will be audited monthly starting February 7th, of 2023 for accuracy and completion by Administrator, or Designee.

> Starting February 7, 2023, all new resident DME Medical Evaluation Forms will be reviewed for accuracy and completion by the Administrator or Designee.

> On February 1, 2023 all DME Medical Evaluation forms for current residents were audited by day shift LPN DW, random monthly audits will continue monthly by day shift Executive Director or Designee to assure compliance.

> Any outstanding or outdated medical evaluations will be brought up to date based on the results of the attached audit. Medical evaluations will be caught up to date by February 24, 2023.

(Directed)

141b1 - Annual Medical Evaluation (continued)

- *Resident #3 had an updated medical evaluation completed on* [redacted]

Directed Completion Date: *02/28/2023*

Implemented (CR - 03/02/2023)

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy labels for Tylenol Arthritis Pain 650mg tablet ER, prescribed for Resident #1 and Resident #2 do not include the prescribed dosage.

On 1/24/2023, the Humalog and Basaglar KwikPens for Resident #2 were not labeled with the staff initials that opened the pens or with a date the pens were opened, per manufacturer's instructions, to ensure it was not used beyond the expiration date.

Plan of Correction ***Directed (CR - 02/10/2023)***

< Executive Director contacted the pharmacy Manager on February 1, 2023. Pharmacy Manager explained that the original container which did not include the dosage amount were sent back to the pharmacy and replaced with packaging that included the correct labeled prescribed dosage. Please see the attached photo of resident #2 corrected labeling received on 1/27/23. New labeling for resident #1 were received Evening Executive Director will re-audit on 2/7/23.

< Med cart audit was conducted by Executive Director and Day LPN on 2/1/23, all Humalog and Basaglar Kwik Pens that were started and not dated were discarded to ensure the medications were not used beyond the expiration date.
A second audit was conducted on 2/3/23 checking all insulin pens, all pens were dated correctly.

>The contracted pharmacy is conducting an audit and checking on all of our residents that are prescribed Acetaminophen to determine if there are any others with dosage not labeled. This audit will be completed on 2/24/23.

> Internal monthly Med Cart audit scheduled to be completed monthly starting on Thursday, February 16th during the overnight shift by Med. Tech/LPN. The audit will include cross checking all physicians written orders against the resident's medication inventory.

> A weekly med cart audit has been implemented to check for proper labeling on all insulin pens in the home. The audits will occur each Thursday night during the overnight shift by the Med-Tech/LPN on duty.

> Moving forward starting in February two separate audits will be conducted by contracted pharmacy a quarterly

184a - Resident's Meds Labeled (continued)

audit that will check for correct labeling and expired medications and corrects dates. The second audit is a consultation audit that will occur every 6 months. Medication contra-indications and inappropriate dosages will be evaluated during this audit.

(Directed)

- *A second med cart audit was conducted on 2/3/23 by the Med Tech checking all insulin pens, all pens were dated correctly.*
- *Starting on 2/13/2023, weekly medication cart was implemented. The audits will be completed by the Med-Tech/LPN on duty on third shift and will check for proper labeling on all insulin pens in the home.*
- *Direct Care, Med Tech's and LPN's will receive education on proper labeling of insulin pens as well as checking medications for proper labeling requirements as as specified in 2600.184(a). Education will be completed by 2/28/2023 by the Director of Clinical education.*

Directed Completion Date: *02/28/2023*

Implemented (CR - 03/02/2023)

185a - Implement Storage Procedures

9. 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 is prescribed Acetaminophen 325mg tablet-650mg by mouth every six hours PRN for rib fractures. On 1/24/2023, this medication was not available in the home.

On 1/24/2023 at approximately 4:00 PM, the following medications were observed in Resident #1's bathroom: Saline Nasal Gel, Triamcinolone cream USP 0.1%, Cortizone-10 cream and Bacitracin Zinc ointment. Resident #1 does not have current physician's orders for these medications and has not been assessed to self administer the listed medications.

Repeated Violation - 11/18/21

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

Resident #1's prescribed Acetaminophen 325mg tablet-650mg by mouth every six hours PRN for rib fractures has been discontinued on February 2, 2023, by primary care physician. Day shift LPN was responsible for getting the order. Please see the attached order to discontinue.

Executive Director and LPN consulted with resident #1 about the following medications, that were located in her bathroom. Saline Nasal Gel, Triamcinolene cream USP 0.1% Cortizone-10 cream and the Bacitracin Zinc ointment. It was decided to obtain an order from primary care physician for the following three medication with a self-administering order. Please see the attached physician medication and self-administration order for Saline Nasal Gel and Triamcinolone cream USP 0.1% (The Cortizone-10 cream, and the Bacitracin Zinc ointment were discarded because they were not being used.

185a - Implement Storage Procedures (continued)

> Internal monthly Med Cart audit scheduled to be completed monthly starting on Thursday, February 16th during the overnight shift by Med. Tech/LPN. The audit will include cross checking all physicians written orders against the resident's medication inventory.

>Staff Education training is scheduled to be completed by Friday, February 28, 2023. The training will include topics on re-ordering medications to ensure medications are always available as ordered for the residents. All Med-Techs and LPN's responsible for distributing medications will be re-trained. Our Director of Clinical Education will be conducting the training.

< Monthly room check safety audits to be instituted starting on Monday February 17, 2023. to assure if there are and over the counter or prescribed medications in a resident's room that we have the necessary orders for the resident's medication. The audits will be conducted by second shift LPN/Med-Tech or PCA. The audits will include checking to ensure the medications are kept locked per the resident's ability to self-administer medications. If a resident is found to have medications in their room and they are not assessed to self-administer, then the medications will be kept locked in the home's medication cart.

>Training will be provided prior by 2/17/23 by the Clinical Nurse Educator to train our PCA's/Med Tech's and LPN's on scanning a resident's room when providing care to ensure medications are kept locked per a resident's RASP.

>The pharmacy is conducting an audit and checking on all of our residents that are prescribed Acetaminophen to determine if there are any others with dosage not labeled. This audit will be completed on 2/24/23. Copy of their documentation attached, new packaging for all residents with dosage cut off on label will be corrected prior to 2/10/23.

On February 2, 2023, order was received by PCP for Resident #1 to self-administer the medications LPN was responsible to receive these orders.

> Moving forward starting in February two separate audits will be conducted by contracted pharmacy a quarterly audit that will check for correct labeling and expired medications and corrects dates. The second audit is a consultation audit that will occur every 6 months. Medication contra-indications and inappropriate dosages will be evaluated during this audit.

Resident #1's RASP was updated by Executive Director on February 9, 2023, to reflect self-administering medications.

Resident #1 was educated by Executive Director on Thursday, February 9, 2023, on properly securing medications being kept in the resident's room. Lock box has been provided to resident by the community.

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: *02/28/2023*

Implemented (CR - 03/02/2023)

191 - Resident Right to Refuse

10. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

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

> Resident #1's resident rights record was corrected on 1/30/23 by the Executive Director.

> On January 30th, 2023, Executive Director sat with resident 1 to review a copy of the resident rights and educated the resident of her rights and the right to question or refuse a medication if the resident believes there may be a medication error. Please see attached document for completed signatures.

> All current resident contracts shall be audited and reviewed and corrected by Administrator, or Designee by 2/17/23. PCHA to assure that all resident rights have been reviewed with resident and are acknowledged appropriately.

> Starting on Wednesday, February 9th, during all new resident contract signings Executive Director or Designee will review the resident rights and complaint procedure forms to assure all required signatures have been reviewed with resident and are acknowledged by signature.

> The attached resident contract audit sheet will be updated monthly; resident contract audit will cover resident rights within the contract to assure that resident rights were reviewed, initialed and signed off on.

Licensee's Proposed Overall Completion Date: *02/09/2023*

Implemented (CR - 03/02/2023)

224a - Preadmission Screen Form

11. Requirements

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

Description of Violation

Resident #1's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

224a - Preadmission Screen Form (continued)

Resident #4 was admitted to the home on [redacted]; however, the resident's preadmission screening form was not completed.

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

> On 2/1/23 the Executive Director addressed the preadmission screening form for resident #1 dated [redacted] was corrected and the indication was noted that the needs of the resident can be met by the services provided by the home. Please see attached and corrected preadmission initialed and dated [redacted]

> The preadmission screening for resident #4 who admitted to the home on [redacted] was completed by the Executive Director on [redacted]. Please see attached completed pre-admission screening for resident #4.

> On Wednesday, February 1, 2023, Executive Director received retraining on regulation 2600 224(a) on the timing and completion of the pre-admission screening.

> Starting Wednesday, February 8, 2023, on the day of move-in, all new resident preadmission screening forms will be reviewed for accuracy and completion by the Executive Director or Designee.

> To be completed by 2/17/23 all resident preadmission screening form for current residents will be audited by day shift LPN.

>The attached resident document audit sheet will be updated monthly; any incomplete pre-screen documents will be completed and audited for completion and accuracy that all residents are appropriate, and we can meet their needs. The audits will be completed by the Executive Director or designee by 2/17/23.

Licensee's Proposed Overall Completion Date: *02/17/2023*

Implemented (CR - 03/02/2023)

225a - Assessment 15 Days

12. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for Resident #1, who was admitted to the home on [redacted].

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

> Resident #1's written initial assessment documented on the Department's assessment form was completed by second shift LPN on [redacted].

>Beginning on Wednesday, February 8th, 2023, the LPN will perform monthly audits to ensure compliance is met for pre-screens, assessments, support plans and DME's.

> Any missing or incomplete Assessment documentation will be completed by LPN prior to 2/17/23.

225a - Assessment 15 Days (continued)

> Beginning on Wednesday, February 8, 2023, at the time of resident move-in the Executive Director or Designee's to audit the new residents move-in paperwork to ensure thoroughness and completion.

> Pre-Screens, Assessments, Support Plans and DME's were audited by LPN. Monthly audits will continue using the attached spreadsheet to assure that compliance is being met moving forward.

Licensee's Proposed Overall Completion Date: *02/09/2023*

Implemented (CR - 03/02/2023)

225c - Additional Assessment

13. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

On 1/24/2023, Resident #3's most recent assessment was completed on [redacted]

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

> Resident #3's written annual assessment, documented on the Department's assessment form was completed by second shift LPN on [redacted]

>An audit was completed by evening supervisor on 2/1/23 to evaluate all resident Pre-Screens, Assessments, Support Plans and DME's.

> Any missing or incomplete Assessment documentation will be completed by 2/17/23.

> Beginning on Wednesday, February 8, 2023, at the time of resident move-in, the Executive Director or Designee's to audit the new residents move-in paperwork to ensure thoroughness and completion.

> Beginning on Wednesday, February 8, 2023, the LPN will perform monthly audits to ensure compliance is met for pre-screens, assessments, support plans and DME's.

Licensee's Proposed Overall Completion Date: *02/09/2023*

Implemented (CR - 03/02/2023)

227a - Support Plan 30 Days

14. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted on [redacted]*; however, the resident's initial support plan was not completed.*

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

> Resident #1's initial Assessment and Support Plan, documented on the Department's RASP form was completed

227a - Support Plan 30 Days (continued)

by second shift LPN on [redacted].

>An audit was completed by evening supervisor on 2/1/23 to evaluate all resident Pre-Screens, Assessments, Support Plans and DME's.

> Any missing or incomplete Support Plan documentation will be completed by 2/17/23.

> Beginning on Wednesday, February 8, 2023, at the time of resident move-in the Executive Director or Designee's to audit the new residents move-in paperwork to ensure thoroughness and completion.

> Beginning on Wednesday, February 8th, 2023, the LPN will perform monthly audits to ensure compliance is met for pre-screens, assessments, support plans and DME's.

Licensee's Proposed Overall Completion Date: *02/09/2023*

Implemented (CR - 03/02/2023)

227c - Support Plan Revision

15. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

On 1/24/2023, Resident #3's most recent support plan was completed on [redacted]

Repeated Violation - 11/18/2021

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

> Resident #3's written annual Support Plan, documented on the Department's assessment form was completed by second shift LPN on [redacted]

>An audit was completed by evening supervisor on 2/1/23 to evaluate all resident Pre-Screens, Assessments, Support Plans and DME's.

> Any missing or incomplete Assessment documentation will be completed by 2/17/23.

> Beginning on February 8, 2023, at the time of resident move-in the Executive Director or Designee's to audit the new residents move-in paperwork to ensure thoroughness and completion.

> Beginning on February 8, 2023, the LPN will perform monthly audits to ensure compliance is met for pre-screens, assessments, support plans and DME's.

Licensee's Proposed Overall Completion Date: *02/09/2023*

Implemented (CR - 03/02/2023)