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

March 8, 2023

[redacted]
HSRE-WSL OF WEXFORD VI TRS LLC
[redacted]

RE: THE WATERS OF WEXFORD
210-212 FOWLER ROAD
WARRENDALE, PA, 15086
LICENSE/COC#: 44936

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/24/2023, 01/26/2023, 01/30/2023 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: *THE WATERS OF WEXFORD* **License #**: *44936* **License Expiration**: *02/21/2024*

Address: *210-212 FOWLER ROAD, WARRENDALE, PA 15086*

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

Administrator

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

Legal Entity

Name: *HSRE-WSL OF WEXFORD VI TRS LLC*

Address: *1600 HOPKINS CROSSROAD, MINNETONKA, MN, 55305*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *05/07/2018* **Issued By**: *Marshall Township*

Type: *I-2* **Date**: *05/17/2018* **Issued By**: *Marshall Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *106* **Waking Staff**: *80*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *01/30/2023*

Inspection Dates and Department Representative

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

01/26/2023 - On-Site: [redacted]

01/30/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *143* **Residents Served**: *78*

Special Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *29* **Residents Served**: *27*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *77*

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

Have Mobility Need: *28* **Have Physical Disability**: *0*

Inspections / Reviews

01/24/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/11/2023*

Inspections / Reviews *(continued)*

02/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/07/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/20/2023*

02/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/07/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/07/2023*

03/08/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/07/2023*

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

25a Resident - residence contract

1. Requirements

2800.
25.a. Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #1 began receiving assisted living services on [redacted], however, resident #1 did not have a written resident-residence contract.

Plan of Correction ***Directed (JK - 02/28/2023)***

Resident #1 was given and signed a resident contract for service. Attached is signed copy for resident #1. All current resident files will be audited by business office manager or director of health and wellbeing to ensure each resident that is receiving services has a signed contract. This audit will be completed by 3/22/23.
Monthly resident file audits will be conducted by business office manager or director of health and wellbeing to ensure all resident files are up to date. These monthly audits will begin 4/1/23 and will be ongoing.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure there is a completed resident-residence contract in place. 2/28/23 JK

Directed Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

41e Signed statement

2. Requirements

2800.
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 ***Directed (JK - 02/28/2023)***

Resident #1 was given and signed document acknowledging receipt of a copy of the resident rights and complaint procedures.
Attached is page 9 of the standard resident contract that all new residents are given. item 13 speaks to complaint procedures and resident rights. Phone number and address for DHS is provided on page 9 as well.
All current resident files will be audited by business office manager by 3/22/23 to ensure each resident file contains a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.
Monthly audits of resident files will be conducted by business office manager to ensure every resident file contains signed copy of resident rights and complaint procedures beginning 4/1/23.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure compliance with Regulation 2800.41(e). 2/28/23 JK

41e Signed statement *(continued)*

Directed Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

51 Criminal background checks

3. Requirements

2800.

51.a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

51.b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

Direct care staff person A, whose first day of work was [redacted] began providing unsupervised direct care services on [redacted] However, direct care staff person A did not have a criminal background check in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. § 10225.101-10225.5102) and 6 Pa.Code Chapter 15 (relating to protective services for older adults.)

Plan of Correction ***Directed (JK - 02/28/2023)***

Direct care staff person A, whose first day of work was[redacted] was employed and began providing unsupervised direct care services prior to a successful criminal background check. Direct care staff person A was hired before the current Business Operations Manager was employed at The Waters. The current Business Operations Manager conducted a background test on[redacted] (attached). The Business Operations Manager will keep the results of the criminal background test in Direct care staff person A's employee file.

The Business Operations Manager practices the current [redacted] background checks and clearances policy that states all applicants are required to submit a criminal history report as part of the application process, specifically upon offer of employment. Background checks will submitted during the application process and prior to the direct care staff person's first day of work.

The Business Operations Manager will review employee files on a monthly basis to ensure background checks were conducted for direct care staff employees before providing unsupervised direct care services.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all staff records to ensure a criminal history background check has been requested for all staff persons. 2/28/23 JK

Directed Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

54a Direct care staff quals

4. Requirements

2800.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person B, whose first day of work was[redacted] began providing unsupervised direct care services on

54a Direct care staff quals (continued)

[redacted] *However, direct care staff person B did not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.*

Direct care staff person C, whose first day of work was [redacted] *began providing unsupervised direct care services on* [redacted]*. However, direct care staff person C did not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.*

Plan of Correction ***Directed (JK - 02/28/2023)***

Direct care staff persons shall present a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry along with appropriate documents to complete their I9 on first day of employment. If all of the documents are not presented, then we will reschedule employees start date (per new hire template attached).
Direct care staff person B has submitted a request to receive a copy of their high school diploma. This diploma will be acquired from staff person B by 3/10/23
The Business Operations Manager will make a copy of the direct care staff person's high school diploma, GED, or active registry status on the direct care staff person's first day. If direct care staff person does not present any of the documents mentioned, then we will send the direct care staff person's home and reschedule their start date.
A monthly audit of employees files will be conducted to confirm a copy of one of the the listed documents is present in the file. Audit will be the responsibility of the business office manager or the executive director.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator the administrator shall review all direct care staff records to ensure all direct care staff meet the regulatory requirements of Regulation 2800.54(a). If a staff person does not meet the requirements that staff person shall not provide direct care services. 2/28/23 JK

Directed Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

63a First Aid/CPR 1:35

5. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

On 1/13/23 there were 76 residents present in the residence, however, direct care staff person D was the only staff person working in the residence who was trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 12:00 a.m. until 7:00 a.m. and from 11:30 p.m. until 12:00 a.m.

On 1/16/23 there were 74 residents present in the residence, however, direct care staff person D was the only staff person working in the residence who was trained in first aid and certified in obstructed airway techniques and CPR from 12:00 a.m. until 7:00 a.m. and from 11:30 p.m. until 12:00 a.m.

On 1/21/23 there were 76 residents present in the residence, however, direct care staff person D was the only staff

63a First Aid/CPR 1:35 (continued)

person working in the residence who was trained in first aid and certified in obstructed airway techniques and CPR from 12:00 a.m. until 7:00 a.m.

On 1/21/23 there were 76 residents present in the residence, however, direct care staff person D and direct care staff person C were the only staff persons working in the residence who were trained in first aid and certified in obstructed airway techniques and CPR from 9:00 p.m. until 11:30 p.m.

On 1/21/23 there were 76 residents present in the residence, however, there were no staff persons working in the residence who were trained in first aid and certified in obstructed airway techniques and CPR from 11:30 p.m. until 12:00 a.m.

On 1/22/23 there were 76 residents present in the residence, however, there were no staff persons working in the residence who were trained in first aid and certified in obstructed airway techniques and CPR from 12:00 a.m. until 7:00 a.m.

Plan of Correction ***Directed (JK - 02/28/2023)***

Immediate
The Director of Health and Wellbeing set up a CPR class on February 2,2023 to have all direct care staff that were not certified attend the course. This is completed.
Maintenance-
To prevent further violations, The Business Office Manager or Director of Health and Wellbeing will ask all new hires for proof of CPR credentials at time of hire. The HSC (scheduler) will ensure that there are the appropriate amount of CPR certified team members working the schedule in order to keep all residents safe. The HSC or Director of Health and Wellbeing will audit all schedules weekly to ensure compliance.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall develop a weekly schedule which includes at least one staff person per 35 residents who trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents. The administrator shall review the past weeks schedule to ensure any schedule changes met the regulatory requirements of 2800.63(a). 2/28/23 JK

63a First Aid/CPR 1:35 (continued)

Directed Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

65e Rights/Abuse 40 Hours

6. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Direct care staff person B, whose first day of work was [redacted], began providing unsupervised direct care services on [redacted]. However, direct care staff person B did not receive orientation in the Emergency Medical Plan

REPEAT VIOLATION 9/15/21 et. al.

Plan of Correction ***Directed (JK - 02/28/2023)***

Staff member B will complete all necessary training for the emergency medical plan by 3/1/23. An audit was completed on 2/20/23 to identify all direct care staff who have not completed an orientation regarding the emergency plan. A training session will be completed by 3/6/23 to ensure all direct care staff are trained. This will be performed by the director of health and well being.
Monthly audits will occur by director of health and well being or executive director to ensure compliance to the on-boarding checklist section that includes training regarding the emergency medical plan, before the directive care person is assigned to work.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current staff records to ensure all staff persons have met the regulatory requirements of Regulation 2800.65(e). 2/28/23 JK

Directed Completion Date: *03/06/2023*

Implemented (JK - 03/08/2023)

65g Initial direct care training

7. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, whose first day of work was [redacted] began providing unsupervised direct care services on [redacted] However, direct care staff person B did not successfully complete and pass the Department-approved direct care training course and pass the competency test.

Direct care staff person C, whose first day of work was [redacted], began providing unsupervised direct care services on [redacted]. However, direct care staff person C, did not successfully complete and pass the Department-approved

65g Initial direct care training (continued)

direct care training course and pass the competency test.

Plan of Correction ***Directed (JK - 02/28/2023)***

Direct care staff person B and staff person C have successful completed and passed Department approved direct care training course and competencies course of 2-24-2023. All direct care staff persons will complete [redacted] training and the direct care staff training and competency test for assisted living residences (ALR) before providing unsupervised direct care services to residences. A certificate of completion for both;[redacted] and ALR training will be kept in employee files.
Review of all staff records identified staff members who have not completed the required training, completion date for these staff members will be 3/1/23.
Monthly audit will be completed by business of manager and the director of health and well being to ensure completion of all staff member training.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current direct care staff records to ensure all direct care staff persons have met the regulatory requirements of Regulation 2800.65(g). 2/28/23 JK

Directed Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

65l Record of training

8. Requirements

2800.
65.l. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The record of training for ancillary staff person E did not include the date, and the length of each course to include:
(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102).
(4) Reporting of reportable incidents and conditions.
(5) Safe management techniques.
(6) Core competency training that includes the following:
i. Person-centered care.
ii. Communication, problem solving and relationship skills.
iii. Nutritional support according to resident preference.

Plan of Correction ***Directed (JK - 02/28/2023)***

POC:
Staff person E will complete all required training listed in 2800 65.l by 3/10/2023.
All employees must attend a training course led by department leaders which covers the violations listed above. The courses provided during the training are shown on the onboarding checklist.
Business of Manager will audit all existing team member training checklist to ensure compliance by 3/10/23.
Monthly checklist audits will be conducted by business office manager to ensure ongoing training compliance.

65l Record of training (continued)

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all staff training records to ensure all current staff training records meet the regulatory requirements of Regulation 2800.65(I). 2/28/23 JK

Directed Completion Date: *03/10/2023*

Implemented (JK - 03/08/2023)

91 Telephone Numbers

9. Requirements

2800.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 1/24/23 at approximately 2:00 p.m. the telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline were not posted on or by the phone in the resident living unit [redacted] belonging to resident #3.

Plan of Correction ***Accept (JK - 02/28/2023)***

Environmental Services Manager posted required phone numbers in [redacted] belonging to resident #3 on 1/26/23. All resident apartments will be checked to ensure each apartment has required phone numbers posted. This audit will be completed by 3/15/23.
Each resident apartment will be checked on the day of move in for all future residents to ensure required phone numbers are present. Move in checklist will be used to ensure compliance. Either Environmental Services Manager or Executive Director will be responsible for compliance.

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

Implemented (JK - 03/08/2023)

101j5 Bedside table/shelf

10. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
5. A bedside table or a shelf.

Description of Violation

On 1/24/23 at approximately 3:31 p.m. there was no bedside table or shelf in resident living unit [redacted] belonging to resident #4.

Plan of Correction ***Accept (JK - 02/28/2023)***

Environmental Service Manager installed shelf next to bed in apt # [redacted] on 2/9/2023. All current resident apartments will be audited by Environmental Service Manager to ensure each apartment has either a bedside table or self. This will be completed by 3/15/23.
Each resident apartment will be checked on the day of move-in for all future residents to ensure required bedside table or shelf are present. Move in checklist will be used to ensure compliance. Either Environmental Services

101j5 Bedside table/shelf (continued)

Manager or Executive Director will be responsible for compliance.

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

Implemented (JK - 03/08/2023)

101j7 Lighting/operable lamp

11. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 1/24/23 at approximately 3:31 p.m. there was no source of light that could be operated from bedside in resident living unit #[redacted] belonging to resident #4.

REPEAT VIOLATION 9/15/21 et. al.

Plan of Correction ***Directed (JK - 02/28/2023)***

Environmental Services Manager installed light next to bed in apt # [redacted] on 2/9/2023.
All current resident apartments will be audited by Environmental Service Manager to ensure each apartment has an operable lamp or other source of lighting that can be turned on at bedside . This will be completed by 3/15/23.

Each resident apartment will be checked on the day of move-in for all future residents to ensure an operable lamp or other source of lighting that can be turned on at bedside. Move in checklist will be used to ensure compliance. Either Environmental Services Manager or Executive Director will be responsible for compliance.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident rooms twice weekly to ensure compliance with Regulation 2800.101(j)(7). 2/28/23 JK

Directed Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

107c Food/water – 3 day supply

12. Requirements

2800.
107.c. The residence shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 1/24/23 the residence served 78 residents, requiring 234 gallons of emergency drinking water. However, the residence had only 100 gallons, and the contract with a local bottled water supplier did not guarantee immediate delivery of water in a local emergency, and did not specify the correct residence for delivery.

Plan of Correction ***Accept (JK - 02/28/2023)***

On 2/2 the community received 120 cases of water that equals 240 + gallons on site. This is a sufficient supply of water for current number of residents.

107c Food/water – 3 day supply (continued)

Water supply will be inventoried monthly on the first day of the month and additional water will be purchased if needed, in order to maintain a minimum of 3 gallons per resident in the community. Additional water will be purchased as needed by Director of Culinary or Executive Director.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

132e Fire drill - sleeping hours

13. Requirements

2800.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The residence did not conduct a sleeping hours fire drill from 8/31/21 until 6/23/22 at 5:40 a.m.

Plan of Correction ***Accept (JK - 02/28/2023)***

A sleeping hours fire drill was performed on 12/28/2021.
However it was mistakenly logged as PM not AM.
To verify the time and date of each fire drill, a photo will be taken of the fire panel. This will show the time, day of the week and date of the alarm. To be completed by Environmental Services Manager.
A fire drill log will be maintained tracking the day of the week as well as time to ensure fire drills will occur on different days of the week and at different times throughout the night. Log will be audited by either Environmental Services Manager or Executive Director on quarterly basis to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

132g Fire drills – days/times

14. Requirements

2800.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The residence conducted both 2022 calendar year sleeping hours fire drills on a Thursday, the first drill on 6/23/22 at approximately 5:40 a.m. and the second drill on 11/17/22 at approximately 5:14 a.m.

Plan of Correction ***Accept (JK - 02/28/2023)***

A fire drill log will be maintained tracking the day of the week as well as time to ensure fire drills will occur on different days of the week and at different times throughout the night. Log will be audited by either Environmental Services Manager or Executive Director on quarterly basis to ensure compliance. Fire drills will be conducted on different days of the week as well as different times throughout the day. Days of the week and times will be noted on the fire drill log in order to ensure fire drill days do not fall on the same days/times throughout the year.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (JK - 03/08/2023)

141a Medical evaluation

15. Requirements

2800.
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:

Description of Violation

Resident #1, who began receiving assisted living services on [redacted] did not have a medical evaluation in [redacted] resident record within 15 days after admission from an acute care hospital.

Resident #5, admitted [redacted], did not have a medical evaluation completed unti[redacted].

Resident #6, admitted [redacted], did not have a medical evaluation completed until [redacted]

Plan of Correction ***Directed (JK - 02/28/2023)***

Immediate: Reeducation has been provided to the team members who are authorized to assist with medical evaluations regarding the importance of timeliness and to ensure compliance with the medical evaluation. This will be completed by director of health and well being by 2/17/23.
Resident 1 was completed on [redacted]
Resident 5 was late and cannot be retroactively corrected.
Resident #6, admitted [redacted] did not have a medical evaluation completed until [redacted]....was within the 30 day admission window.

Maintenance: To prevent further violations from occurring for any resident that has an outside provider the resident or family will be given the ADME form to take to their physician for completion prior to admission to the community for services and annually. Audits will occur monthly by D.H.W.B. or nursing supervisor to maintain compliance.

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure an accurate, complete, and current medical evaluation has been completed for each resident and the documentation is in the resident record. 2/28/23 JK

Directed Completion Date: *02/24/2023*

Implemented (JK - 03/08/2023)

183d Current medications

16. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 1/26/23 resident #6's Polyethylene Glycol 3350 powder was unlocked, unattended, and accessible on the residence's fourth floor medication cart. However, resident #6's Polyethylene Glycol 3350 powder was discontinued on 11/14/22.

Plan of Correction ***Directed (JK - 02/28/2023)***

Immediate: The medication was immediately pulled from the Medication cart on 1/26/23. Reeducation has been

183d Current medications (continued)

provided to the team members who are authorized to administer medications. This re-education was completed 2/8/23.

Maintenance: Medication cart audits will occur daily by the staff responsible to the cart (see attached audit) and the carts will be audited weekly by the Director of Health and Wellbeing or nursing supervisor.
Monthly apartment audits will be conducted by D.H.W.B. or nursing supervisor to ensure no expired medications are on hand.

DIRECTED
Within ten calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons qualified to administer medications on the requirements of Regulation 2800.183(d). Documentation of education shall be kept. 2/28/23 JK

Directed Completion Date: *03/06/2023*

Implemented (JK - 03/08/2023)

185a Storage procedures

17. Requirements

2800.
185.a. The residence 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 #7 is prescribed Hyoscyamine 0.125MG – Take one tablet sublingually every 4 hours as needed. However, on 1/26/23 at approximately 10:40 a.m., the medication is not in the medication cart or in the home to administer if requested.

Resident #7 is prescribed Lorazepam 1MG/0.5mL Oral Solution – Take 1MG (0.5mL) sublingually every 4 hours as needed. However, on 1/26/23 at approximately 10:40 a.m., the medication is not in the medication cart or in the home to administer if requested.

Resident #7 is prescribed Morphine Concentrate 10 MG/0.5mL Oral Solution – Take 10MG (0.5mL) sublingually every 2 hours as needed. However, on 1/26/23 at approximately 10:40 a.m., the medication is not in the medication cart or in the home to administer if requested.

Resident #7 is prescribed Ondansetron Tablets 4MG – Dissolve one tablet sublingually every 6 hours as needed. However, on 1/26/23 at approximately 10:40 a.m., the medication is not in the medication cart or in the home to administer if requested.

Resident #7 is prescribed Scopolamine DISC 1MG/3Day – Apply one patch topically every 72 hours as needed. However, on 1/26/23 at approximately 10:40 a.m., the medication is not in the medication cart or in the home to administer if requested.

REPEAT VIOLATION 9/15/21 et. al.

Plan of Correction ***Directed (JK - 02/28/2023)***

Immediate: The items contained in the emergency kit referenced for resident 7 were immediately discontinued on

185a Storage procedures (continued)

1/26/2023 by nursing supervisor and responsible pharmacy.

Maintenance: Upon admission to Hospice, residents will have an assessment performed and the Hospice nurse and community nurse will determine appropriateness of e-kit order.
Monthly audits of Hospice orders will be completed by D.H.W.B. or nursing supervisor.

DIRECTED
Within 10 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons qualified to administer medications on the home's policy and procedures for the safe storage, access, security, distribution and use of medications and medical equipment including the requirement to have all prescribed medications in the home and available for administration. This includes the home's policy and procedures for reordering medications as needed. Documentation of education shall be kept. 2/28/23 JK

Directed Completion Date: *03/06/2023*

Implemented (JK - 03/08/2023)

191 Resident right to refuse

18. Requirements

2800.
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

There is no documentation that resident #1 has been educated on the right to question or refuse a medication if the resident believes there may be a medication error.

Plan of Correction ***Accept (JK - 02/28/2023)***

Resident #1 was educated on [redacted] on their right to refuse medication. All resident files will be audited to ensure there is a signed right to refuse medication document in their files. This audit will be completed by business office manager and will be completed by 3/15/23
All new residents will be educated on their right to refuse medications and document kept in their resident file effective 2/25/23.
Monthly audits of resident files to ensure rights to refuse medication documentation will be completed by business office manger or executive director. These audits will be ongoing beginning 4/1/23

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

Implemented (JK - 03/08/2023)

224a5 Written initial assessment

19. Requirements

2800.
224.a.5. The written initial assessment must, at a minimum include the following:
iii. The ability of the individual to self-administer medication.

Description of Violation

Resident #3's assessment and final support plan, reviewed and updated on [redacted] indicated the resident was able to self-administer all medications. However, resident #3's medical evaluation, dated [redacted], indicated the resident

224a5 Written initial assessment (continued)

cannot self-administer medications.

Plan of Correction ***Directed (JK - 02/28/2023)***

Immediate-
Re education has been provided to the team members who are authorized to assist with the assessments and support plan to ensure they align with the medical evaluation. All resident medical charts were audited for compliance, Completed by D.H.W.B. on 2/8/2023.
Maintenance-
To prevent further violations The Director of Health and Wellbeing or designee will review each medical evaluation upon completion and upon arrival to community to ensure that it aligns with the initial assessment. Compliance will be the responsibility of D.H.W.B. or nursing supervisor.
Monthly audits of medical evaluation and assessments will occur to ensure compliance that they align with care. Audit to be conducted by D.H.W.B. or nursing supervisor.

DIRECTED
Within 10 calendar days of receipt of the accepted plan of correction: The administrator shall audit all resident records to ensure an accurate and complete assessment has been completed for each resident and is in the resident record. 2/28/23. JK

Directed Completion Date: *02/24/2023*

Implemented (JK - 03/08/2023)

231c1 Preadmit screening

20. Requirements

2800.
231.c.1.i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Description of Violation

Resident #8's written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form for admission to the residence's special care unit was not dated.

Plan of Correction ***Directed (JK - 02/28/2023)***

Immediate-
Re-education has been provided to the team members who are authorized to assist with the admissions to ensure all cognitive screens are completed 72 hours prior to being admitted to a special care unit. Completed by D.H.W.B. by 2/8/2023.
Resident #8 cognitive pre-admission screening could not be retroactively dated however medical doctor reviewed said screening and dated on
Maintenance-
To prevent further violations The Director of Health and Wellbeing or designee will review each resident's paperwork to ensure that the screening to a specialty care unit is completed and signed within 72 hours of admission. Ongoing compliance will be the responsibility of D.H.W.B. or nursing supervisor as performed through monthly audits.

DIRECTED
Within 10 calendar days of receipt of the accepted plan of correction: The administrator shall audit all resident

231c1 Preadmit screening (continued)

records to ensure an accurate and complete cognitive screening has been completed for each resident in the special care unit and is in the resident record. 2/28/23. JK

Directed Completion Date: *02/24/2023*

Implemented (JK - 03/08/2023)

252 Records – content

21. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

The resident record for resident #2 did not contain a photograph of the resident that was no more than two years old.

The resident record for resident #3 did not contain a photograph of the resident that was no more than two years old.

The resident record for resident #6 did not contain a photograph of the resident that was no more than two years old.

The resident record for resident #8 did not contain a photograph of the resident that was no more than two years old.

The resident record for resident #9 did not contain a photograph of the resident that was no more than two years old.

Plan of Correction ***Accept (JK - 02/28/2023)***

The Waters of Wexford's prospect to resident checklist is an internal document to accompany each prospective resident file. The checklist has a section for a resident photo to be taken upon arrival at The Waters of Wexford. Resident files will be updated with current photos of the resident that are no more than 2 years old. Photos will be dated to ensure that the photo is not older than two years old. For Residents 2,3,6,8 current photographs have been taken and updated in resident file. To be completed by active life manager by 3/10/2023.
All residents will have new photograph taken by 3/22/23 to ensure a current photo is on file. A spreadsheet will be used to track the date photo was taken and within two years a new photo will be taken. Active Life manager will be responsible for taking photos and tracking spreadsheet.

Licensee's Proposed Overall Completion Date: *03/22/2023*

Implemented (JK - 03/08/2023)