pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 17, 2023

[redacted]
Luther Ridge Facility Operations LLC
160 Red Horse Road
Pottsville, Pennsylvania 17901

RE: Luther Ridge at Seiders Hill
License: 224661

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on March 9, 2023, March 10, 2023, March 16, 2023, July 20, 2023, August 23, 2023, and September 14, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), the Department hereby REVOKES your certificate of compliance (license number 224660) dated March 12, 2023, to March 12, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated March 12, 2023, to March 12, 2024, is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to <62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 17, 2023 to April 17, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing Room
631, Health and Welfare Building 625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary>
cc: [redacted]

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

Facility Information

Name: *LUTHER RIDGE AT SEIDERS HILL* **License #:** *22466* **License Expiration:** *03/12/2023*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *LUTHER RIDGE FACILITY OPERATIONS LLC*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA, 17901*

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

[redacted] of Occupancy

Type: *C-2 LP* **Date:** *06/23/1999* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *96* **Waking Staff:** *72*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *03/16/2023*

Inspection Dates and Department Representative

03/09/2023 - On-Site: [redacted]
03/10/2023 - On-Site:
03/16/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served:** *74*

Special Care Unit

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

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *73*

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

Have Mobility Need: *22* **Have Physical Disability:** *0*

Inspections / Reviews

03/09/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/06/2023*

05/04/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/28/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/16/2023*

06/09/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/28/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/15/2023*

09/29/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/28/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

16c Incident reporting

1. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1 is prescribed Hydrocodone-Acetaminophen 7.5/325mg 3 times daily at 7am, 12pm, and 5pm. Due to the medication not being in the facility, Resident #1 missed all 3 doses of the medication on 3/9/23, and the 7am and 12pm doses as of 3/10/23 at 1:21pm. This was not reported to the Department until 3/10/23 at 3:30pm.

Plan of Correction ***Accept [redacted] - 05/24/2023)***

ED received a refill script and med was sent from the pharmacy the same day it was brought to ED attention during survey.

5/1 Education completed with staff who are certified to pass meds to notify DON and/or ED/Designee immediately if there is an issue obtaining a refill script. Also reeducated on the importance of reporting to ED immediately if any medication is not available to administer. An Audit was completed of all resident Narcotic medication by ED on 3/10. All resident medication was audited by ED on 3/13 and 3/14. Starting 5/22 two residents medications per med cart (6 carts) will be audited weekly x 4 and then monthly by DON/Designee to be reported to ED at monthly Quality Management meeting.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented [redacted] - 09/29/2023)

18 Other laws, regs, ordins.

2. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Carbon Monoxide detectors in the Library and the Boiler room had batteries that were last changed 5/24/2021. The Care Facility Carbon Monoxide Alarms Standard Act requires that the batteries be changed annually.

Plan of Correction ***[redacted] - 05/04/2023)***

All batteries were changed immediately 3/10/23 upon recognizing they were out of compliance. New maintenance director aware of need to change batteries annually. ED documented need to change batteries on Calander for 2/2024 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *04/24/2023*

Implemented [redacted] - 09/29/2023)

25b Contract signatures and renewal

3. Requirements

2800.

25b Contract signatures and renewal *(continued)*

25b . 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. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

The contract dated 4/26/2022 for Resident #2 and the contract dated 6/20/2022 for Resident #3 were not signed by the residents and does not indicate that they refused to sign or were unable to sign.

Plan of Correction ***Accept ([redacted] - 05/04/2023)***

Resident #2 and Resident #3 have not been facility to sign as resident #2 in hospital and Resident #3 was not accepted back to facility after rehab stay and was discharged to LTC.

All current resident files were audited to assure signatures were obtained per regulation.

ED will review all new admission charts at least monthly to assure compliance.

Licensee's Proposed Overall Completion Date: *04/24/2023*

Implemented [redacted] - 09/29/2023)

42s Privacy - self/possessions

4. Requirements

2800.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home is utilizing a voice controlled electronic device in the dining room. There is no written notification that conversations may be recorded by the device, and no home policy regarding this electronic device or the staff with administrative rights on the device.

Plan of Correction ***Accept [redacted] - 05/24/2023)***

The Alexa was removed from the dining room. Management and med trained staff were educated on regulation and that no Alexa or Alexa type devices may be used until further notice on 5/1 by ED. They were also educated to inform ED if an Alexa or Alexa type device were to come into building. ED will address immediately if an Alexa device is reported in the community and will also monitor for Alexa type devices during monthly rounds for QA meeting.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented ([redacted] - 09/29/2023)

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

The home has 74 residents, which requires 3 staff persons 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. . On 2/24/23 and

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

2/25/23, from the hours of 11pm until 6:30am, there were only 2 staff persons present in the home trained in first aid and CPR. On 2/26/22, from the hours of 11pm until 6:30am, there was only 1 staff person present in the home trained in first aid and CPR.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

All CPR certifications were audited by Administrator. CPR class was held 5/2 by Earl Ostrander from CPR Road Tour, to get nursing staff up to date. DON or designee will ensure staff up to date and required number of CPR certified staff in building at all times. ED will review CPR certification dates with DON monthly with Quality Assurance.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented [redacted] - 09/29/2023)

65a Fire Safety-1st day

6. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff person A, date of hire [redacted] 2/22, did not receive orientation on any of the topics required by this regulation.

Plan of Correction ***Accept ([redacted] 06/09/2023)***

Staff person A received the required orientation by HR on 4/28. HR did an audit of all staff files to verify in compliance.. HR will ensure all staff moving forward have training per regulation and all new hire files will be audited monthly by ED/Designee to ensure compliance.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Not Implemented [redacted] - 09/29/2023)

65e Rights/Abuse 40 Hours

7. 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

Staff person A, date of hire [redacted] /22, did not receive orientation on any of the topics required by this regulation by the end of their first 40 hours of work.

Plan of Correction ***Accept ([redacted] - 06/09/2023)***

Staff person A received the required orientation by HR 4/28. HR audited all staff files to ensure all training was completed as per regulation. HR will ensure all staff moving forward have training per regulation and all new hire files will be audited monthly by ED/Designee to ensure compliance.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Not Implemented [redacted] - 09/29/2023)

65h 16 hrs annual training

8. Requirements

2800.
65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

The home was unable to verify that Direct care staff person C received any of the required 16 hours of annual training relating to [redacted] job duties during training year 2022.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

HR and ED/Designee will review training hours for all staff monthly during Quality management meeting to ensure training compliance for 2023. Staff person C works limited hours and will have training completed by 5/22/23

Licensee's Proposed Overall Completion Date: *05/22/2023*

Not Implemented [redacted] - 09/29/2023)

65i Training topics

9. Requirements

2800.
65.i. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct care staff person B did not receive training in the following topics in training year 2022: 1. Medication self-administration training; 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan; or 5. Assisted living service needs of the resident.

Direct care staff person C did not receive annual training in any of the topics required by this regulation in training year 2022.

Plan of Correction ***Accept[redacted] - 06/09/2023)***

HR and ED/Designee will review training hours for all staff monthly during Quality management meeting to ensure training compliance for 2023. Staff person C will complete required training on 5/22/23.

Licensee's Proposed Overall Completion Date: *05/22/2023*

Not Implemented ([redacted]/29/2023)

65j Annual training content

10. Requirements

2800.
65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Staff person B did not receive annual training in the following topics in training year 2022: 1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert; or 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).

Staff person C did not receive annual training in any of the topics required by this regulation in training year 2022.

65j Annual training content *(continued)*

Plan of Correction ***Accept (JH - 06/09/2023)***

HR and ED/Designee will review training hours for all staff monthly during Quality management meeting to ensure training compliance for 2023. Staff person B will complete training on 5/22/23.

Licensee's Proposed Overall Completion Date: *05/22/2023*

Not Implemented [redacted] - 09/29/2023)

91 Telephone Numbers

11. 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

There were no emergency numbers posted near the landline telephone in the room of Resident #4.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

Emergency numbers were posted at resident #4 phone day observed missing. Housekeeping audited all resident room with a landline to ensure emergency numbers posted on 3/10/23. Posting of emergency numbers for landline phones added to admission checklist to ensure all newly admitted residents who bring a landline have numbers posted. ED will monitor for compliance monthly with rounds for monthly Quality management meeting.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented [redacted] - 09/29/2023)

101j7 Lighting/operable lamp

12. 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

There was no lamp or light accessible bedside in the room of Resident #5.

Plan of Correction ***Accept [redacted] - 05/04/2023)***

Lamp was put at bedside for resident #5 day was observed missing. ED/Designee will monitor for ongoing compliance during monthly rounds for Quality Management meeting.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] 09/29/2023)

132b Safety inspection/fire drill

13. Requirements

2800.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

132b Safety inspection/fire drill *(continued)*

Description of Violation

The home's most recent fire safety inspection was conducted on 8/31/22. The previous fire safety inspection and supervised fire drill were conducted on 6/22/21. This exceeds the annual time frame as required by this regulation.

Plan of Correction ***Accept[redacted] - 05/04/2023)***

Phone call was placed to fire safety expert to schedule 2023 training for July to ensure compliance. ED/Designee will ensure completed prior to 8/31/23

Licensee's Proposed Overall Completion Date: *08/31/2023*

Not Implemented[redacted] - 09/29/2023)

132d Evacuation

14. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

Per the home's fire safety inspection conducted 8/31/22, the home was granted a safe evacuation time of 9 minutes. The fire drill conducted on 1/19/23 at 12:30am had a recorded evacuation time of 9 minutes and 26 seconds, exceeding the home's safe evacuation time.

Plan of Correction ***Accept[redacted] - 06/09/2023)***

The fire drill from 1/19 was repeated and was completed on 2/2/23 within the 9 minutes approved by fire safety expert (8min 44sec). Maintenance director/ED/Designee will ensure staff educated on evacuation procedures to assure safe and timely evacuation times during fire drills. ED/Designee will monitor fire drills/times monthly. Fire safety in service scheduled for Thursday 5/26 by ED (Fire Safety Train the Trainer) and maintenance Director.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Implemented[redacted] - 09/29/2023)

171b5 Transportation-first aid kit

15. Requirements

2800.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2800.96 (relating to first aid kit). The inclusion of an automatic external defibrillation device in a vehicle is optional.

Description of Violation

The first aid kit in the home's transport vehicle did not include scissors or eye coverings.

Plan of Correction ***Accept[redacted] 05/04/2023)***

Scissors and eye coverings were added day observed missing. DON/Designee will audit first aid kits monthly. Ed will monitor for compliance monthly during Quality Management meeting.

Licensee's Proposed Overall Completion Date: *05/02/2023*

Implemented ([redacted] - 09/29/2023)

181c Self-Administer Assessment

16. Requirements

2800.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 is prescribed Dicolfenac Sodium Gel 1% which is stored unlocked in the resident's bedroom. Resident #1 is not currently assessed to be able self-administer medication without assistance and therefore medication may not be stored in their living unit.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

Dicolfenac gel was removed from resident room immediately when observed in room. Staff re-educated on need to have meds locked in med cart for all residents who do not self administer on 5/1. ED/Designee will monitor for compliance during rounds for monthly Quality Management meeting.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented [redacted] - 09/29/2023)

181d Self-administer Storing medication

17. Requirements

2800.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's living unit for self-administration. Medications stored in the resident's living unit shall be kept locked in a safe and secure location to protect against contamination, spillage and theft. The residence shall provide a lockable storage unit for this purpose.

Description of Violation

Resident #6 self-administers all of their medications. The medications were not locked at the time of inspection. The resident states that they do not lock the medication storage cabinet in their room and that they do not always lock their bedroom door when they exit the room.

Plan of Correction ***Accept[redacted] - 06/09/2023)***

Resident #6 was reeducated on the need to keep door to room locked at all times on 3/10/23. A check was added to MAR for med tech to monitor compliance. Compliance will be monitored by ED during monthly rounds fro Quality Management.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Not Implemented [redacted] - 09/29/2023)

185a Storage procedures

18. 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 Bisacodyl Rectal Suppository 10mg as needed. This medication was not available in the residence at time of inspection.

185a Storage procedures (continued)

Per the home's controlled substance policy, off-coming and on-coming Med Techs for each shift count all of the controlled substances in the medication carts and sign their name in the home's Controlled Substance Count Sign-Off Sheet after the count is completed. On 3/10/23, Staff Person D and Staff Person E both signed ahead as the "off-going" staff persons before the controlled substance count was completed.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

Bisacodyl Rectal Suppositories were reordered 3/10/23 and placed in cart. Cart audit was completed to assure all medication present per orders. DON/Designee will audit monthly to assure compliance. ED/Designee will review audits monthly during QA meeting to ensure ongoing compliance. Medication carts were audited 3/13 and 3/14 by ED.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented [redacted] - 09/29/2023)

187a Medication record

19. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #5 is prescribed Vit Deficiency System B12 Injection once per month. This medication was administered on 3/1/23; however, it is not included on the resident's medication administration record that the medication was administered.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

Resident #5 B12 was administered by LPN. LPN made a late entry that medication was administered. Med trained staff reeducated on need to assure administrations of medications are documented on 5/1/23 by ED. DON/Designee will audit emar at least weekly to monitor for compliance. Emar audit will be reported by DON/Designee during monthly Quality Management meeting so ED/Designee can monitor for continued compliance.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented [redacted] - 09/29/2023)

187d Follow prescriber's orders

20. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is prescribed Hydrocodone-Acetaminophen 7.5/325mg 3 times daily at 7am, 12pm, and 5pm. Due to the medication not being in the facility, Resident #1 missed all 3 doses of the medication on 3/9/23, and the 7am and 12pm doses as of 3/10/23 at 1:21pm.

Resident #2 is prescribed Insulin Aspart FlexPen Solution Pen-Injector 100u/ml, to inject 7 units before meals. On 2/1/23, 2/2/23, 2/6/23, 2/7/23, 2/9/23, 2/11/23, and 2/12/23 at 5:00pm, the resident's MAR indicates "Insulin Not Required" and that the insulin was not administered.

187d Follow prescriber's orders (continued)

Resident #2 is prescribed Santyl External Ointment 250u/gm, to be applied to wound daily. On 1/25/23, 1/26/23, 1/28/23, 1/29/23, 1/30/23, 2/10/23, it was not indicated on the resident's MAR that this treatment was administered.

Resident #2 is prescribed wound packing with alginate and cover with 4x4 gauze of right heel one time daily. On 2/10/23, 2/12/23, and 2/13/23, it was not indicated on the resident's MAR that this treatment was administered.

Resident #7 is prescribed Metoprolol 25mg, with parameters to hold the medication if the resident's systolic blood pressure is under 100 or heart rate is under 60bpm. On 3/3/23, 3/5/23, 3/6/23, 3/9/23 and 3/10/23, staff did not measure Resident #7's blood pressure to be able to administer or hold the medication correctly.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

Resident #1: Staff was requesting refill orders from pain management, and they were not responsive. ED called pain management and they stated they would try to get script over. To assure med was available ED contacted PCP who sent a script with enough meds to cover the weekend. Meds were delivered same day.

Resident #2: was noncompliant and had multiple refusals. Resident remains out of the facility and more than likely will not be readmitted related to refusals, noncompliance and resistance to care.

Resident #7; Medtech who did not take B/P has been taken off of meds. DON reported to PCP and POA. MARs will be monitored by ED/Designee weekly x 4 and then monthly to ensure ongoing compliance. Medication staff were retrained 5/1/23 by ED. MAR Audit completed by DON 3/13 and 3/14.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented ([redacted] - 09/29/2023)

190a Completion of course–meds

21. Requirements

2800.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Person F, Staff Person G, Staff Person H, Staff Person I, and Staff Person J all administer medications to residents. However, all aforementioned staff persons' most recent Medication Administration Annual Practicums are incomplete due to missing documentation and are not currently qualified to administer medications.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

Annual practicums completed for those that were incomplete by [redacted], certified med tech trainer, 3/2023. DON/Designee will assure paperwork complete after practicums completed by med trainer. ED/designee will review during monthly Quality assurance to ensure continued compliance..

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented [redacted] - 09/29/2023)

190b Insulin injections

22. Requirements

2800.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff Person F, Staff Person G, and Staff Person H have administered insulin. The Staff Persons' insulin administration trainings expired 2/7/2023.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

ED audited all insulin training 3/10/13. Staff persons with expired insulin training are not currently administering insulin. Staff person F completed diabetic training on 4/10 with the LVH Diabetic trainer. Staff persons G and H are scheduled for the LVH diabetic training in June. DON/Designee will review training material monthly to ensure compliance. ED/Designee will review monthly to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented [redacted] - 09/29/2023)

227d Support plan – med/dental

23. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Per staff interviews, Resident #2 is often resistant and/or noncompliant with AM and/or PM care, can be verbally aggressive toward staff, uses sexually suggestive language with staff, can be resistant with incontinence care, and only allows certain staff members to provide care. Staff also expressed not completing Resident #2's care alone due to [redacted] verbally aggressive and sexually suggestive language. Resident #2's assessment and support plan (ASP) dated 4/28/22, does not list these behaviors or the home's plan to meet the resident's needs based on these behaviors.

The ASP dated 6/12/2022 for Resident #8 does not indicate that the resident utilizes an enable bar on their bed.

Plan of Correction ***Accept ([redacted] 06/09/2023)***

ASP for resident #8 was updated 3/10. DON/Designee aware of need to assure ASPs updated as needed. All ASPs will be reviewed to assure compliance by 5/26. ED/Designee will review all new ASPs monthly to assure information included per regulation.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Implemented [redacted] - 09/29/2023)

227g Support plan - signatures

24. Requirements

227g Support plan - signatures *(continued)*

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The most recent ASP for Resident #9 was not signed by the assessor.

Plan of Correction ***Accept [redacted] - 06/09/2023)***

The ASP for resident #9 was signed by assessor 3/10. ASPs will be audited for signatures by 5/26. DON/Designee will monitor for compliance monthly. DON will review ASPS monthly with ED during QA to assure ongoing compliance.

Licensee's Proposed Overall Completion Date: *05/26/2023*

Implemented [redacted] - 09/29/2023)

252 Records – content

25. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

The case record for Resident #2 does not indicate if the resident has any identifying marks.

Plan of Correction ***Accept [redacted] 06/09/2023)***

Resident #2 was out to hospital at time of inspection and has not returned. All resident charts audited 3/17 to ensure identifying marks not missing. DON/designee to ensure identifying marks documented for all new admissions and ED/Designee will review all new resident charts during monthly QA to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented [redacted] - 09/29/2023)