pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **KJ BETHEL PARK LLC**
LEGAL ENTITY

To operate **THE SHERIDAN AT BETHEL PARK**
NAME OF FACILITY OR AGENCY

Located at **2000 COOL SPRINGS DRIVE, PITTSBURGH, PA 15234**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **147** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 1,** **2023** until **June 1,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **449482**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 1, 2023

[redacted]
KJ Bethel Park LLC
2000 Cool Springs Drive
Pittsburgh, Pennsylvania 15234

RE: The Sheridan at Bethel Park
License/COC #: 449482

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on March 22, 2023, March 23, 2023, March 24, 2023, April 3, 2023, May 3, 2023, May 4, 2023, June 27, 2023, June 28, 2023, and June 29, 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. 2600 (relating to Personal Care Homes), mistreatment or abuse, failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from December 1, 2023 to June 1, 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. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
16(c)	II	111	$5	$555	5 calendar days from mailing date of this letter
23(a)	II	111	$5	$555	5 calendar days from mailing date of this letter
141(a)	II	111	$5	$555	5 calendar days from mailing date of this letter
141(b)(1)	II	111	$5	$555	5 calendar days from mailing date of this letter
184(a)	II	111	$5	$555	5 calendar days from mailing date of this letter
185(a)	II	111	$5	$555	5 calendar days from mailing date of this letter
187(d)	II	111	$5	$555	5 calendar days from mailing date of this letter
225(c)	II	111	$5	$555	5 calendar days from mailing date of this letter
227(d)	II	111	$5	$555	5 calendar days from mailing date of this letter
231(b)	II	111	$5	$555	5 calendar days from mailing date of this letter
234(a)	II	111	$5	$555	5 calendar days from mailing date of this letter
3(c)	III	111	$3	$333	15 calendar days from mailing date of this letter
17	III	111	$3	$333	15 calendar days from mailing date of this letter
103(e)	III	111	$3	$333	15 calendar days from mailing date of this letter
183(d)	II	111	$5	$555	5 calendar days from mailing date of this letter

191	II	111	$5	$555	5 calendar days from mailing date of this letter
224(a)	II	111	$5	$555	5 calendar days from mailing date of this letter
225(a)	II	111	$5	$555	5 calendar days from mailing date of this letter
227(a)	II	111	$5	$555	5 calendar days from mailing date of this letter
227(c)	II	111	$5	$555	5 calendar days from mailing date of this letter
227(g)	II	111	$5	$555	5 calendar days from mailing date of this letter
231(c)	II	111	$5	$555	5 calendar days from mailing date of this letter
231(e)	II	111	$5	$555	5 calendar days from mailing date of this letter
25(b)	II	111	$5	$555	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

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], Workload Manager
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: *THE SHERIDAN AT BETHEL PARK* **License #:** *44948* **License Expiration:** *10/14/2023*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA 15234*

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

Administrator

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

Legal Entity

Name: *KJ BETHEL PARK LLC*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA, 15234*

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *12/13/2019* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *174* **Waking Staff:** *131*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *04/28/2023*

Inspection Dates and Department Representative

03/22/2023 - On-Site: [redacted]
03/23/2023 - On-Site:
03/24/2023 - On-Site:
04/03/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* **Residents Served:** *115*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *MC1 & MC2* **Capacity:** *40* **Residents Served:** *26*

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *109*
Diagnosed with Mental Illness: *2*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *59*
Have Physical Disability: *0*

Inspections / Reviews

03/22/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/12/2023*

05/11/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/15/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/17/2023*

05/15/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/15/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/12/2023*

09/22/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/15/2023*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 3/24/23 at approximately 11:45 AM, then again on 4/3/23 at approximately 9:50 AM, an agent of the Department requested resident #1's record; however, the record was not provided to the agent of the Department. Also, on 4/5/23, an agent of the Department requested resident #1's most recent medical evaluation and most recent assessment and support plan; however, the documents were not provided to the agent of the Department.

On 4/3/23, an agent of the Department requested resident demographic information and the direct care staffing schedule/punch cards for numerous dates from staff person [redacted] the home's administrator; however, the information was not provided to the agent of the Department.

Plan of Correction ***Accept ([redacted] - 05/15/2023)***

• On 5/11/2023 An education on regulation 2600.5.a.1 was provided to all administrative staff and management. (Please see Exhibit-1.A)
• On 5/11/2023 Action was taken to move all previous resident files to an easily accessible location as to comply with timely requests regarding previous resident files.
• Resident demographic information available on site upon request via internal network. Network Access to documentation has been granted to ED and BOM as back up as of 4/10/2023. If ED is unavailable BOM is available to produce demographic and schedule/punch card information.
• On 05/16/2023 An audit to begin of previous resident files and their organization within the community by ED or designee 2 times weekly for 4 weeks followed by 1 time weekly for 4 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 1.B)

Licensee's Proposed Overall Completion Date: *06/22/2023*

Implemented [redacted] - 09/22/2023)

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

Numerous medication errors occurred in the home during the month of March, 2023, including medication errors involving residents #2, #3, #10 and #12; however, the medication errors were not reported to the Department.

REPEAT VIOLATION: 8/1/2022, et. al.

16c - Written Incident Report *(continued)*

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/05/2023 medication errors listed in license inspection summary were sent to the department of human services retroactively by ED.
• On 05/11/2023 All Staff educated on reportable Incidents, 24 hours to report, and all incidents specified under 2600.16.c by ED. Documentation of educations to be kept in the home. (Please see Exhibit-2.A)
• Written incident reporting and timeliness to be discussed daily at stand up. Staff in attendance to be included in daily stand-up documentation. In tandem with monthly education in QA meetings. (Please see Exhibit-2.B)
(DIRECTED: The daily review of internal incidents shall begin on 5/17/23 to ensure all reportable incidents specified in 2600.16a are reported to the Department within 24 hours. [redacted] 5/15/23).
• Monthly education in QA meetings to occur for 4 months regarding timely reporting as stated in chapter 2600.16. ongoing. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month.
(DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23).

Directed Completion Date: *06/01/2023*

Not Implemented [redacted] - 09/22/2023)

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

On [redacted]23 at [redacted] AM, resident #4 activated her call bell for assistance; however, a staff person did not respond to the call bell until [redacted] AM. During the 3 hours, 43 minutes resident #4 was waiting for staff assistance, resident #4 became trapped between [redacted] bed and the enabler bar on the side of [redacted] bed. Resident #4 was sent to the hospital and admitted with numerous injuries, including an extensive skin tear over the left hand with exposure of the tendon and underlying tissue, numerous skin tears to the left and right forearms, multiple abrasions and contusions. According to resident #4's most recent assessment, dated [redacted]/22, resident #4 requires physical assistance from staff persons to transfer in/out of bed/chair, toileting, ambulating and personal hygiene.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On [redacted]/2023 ED suspended staff persons responsible for resident #4, pending an investigation based on delayed call light response time.
• On [redacted]/2023 staff persons responsible for resident #4 care were terminated from the Community.
• On 05/15/2023 ED will monitor Call bell report from previous week and weekly thereafter. Call bell response time documentation to be kept in home.
• On 05/11/2023An education was provided to Direct Care Staff by ED on regulation 2600.23.a (Exhibit-3.A)
(DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 5/15/23).

23a - Activities of Daily Living Assistance (continued)

• On 05/11/2023 all current resident support plans were audited for accuracy by HWD or designee. (Exhibit-3.B)
• On 05/15/2023 ED or designee to audit 4 resident care plans weekly for 2 weeks followed by 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Documentation shall be kept in the home. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Exhibit-3.C) (DIRECTED: The ED or designee shall also interview the residents selected to ensure each resident is receiving assistance with ADL's in accordance with their assessment and support plan. Documentation of the interviews shall be kept. [redacted] 5/15/23). DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept.[redacted] 5/15/23

Directed Completion Date: *06/12/2023*

Not Implemented [redacted] - 09/22/2023)

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted]23 at [redacted] AM, resident #4 activated [redacted] call bell for assistance; however, a staff person did not respond to the call bell until [redacted] AM. During the 3 hours, 43 minutes resident #4 was waiting for staff assistance, resident #4 became trapped between [redacted] bed and the enabler bar on the side of [redacted] bed. Resident #4 was sent to the hospital and admitted with numerous injuries, including an extensive skin tear over the left hand with exposure of the tendon and underlying tissue, numerous skin tears to the left and right forearms, multiple abrasions and contusions. According to resident #4's most recent assessment, dated [redacted]22, resident #4 requires physical assistance from staff persons to transfer in/out of bed/chair, toileting, ambulating and personal hygiene.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/10/2023 the ED submitted a State reportable form relaying the information retro actively to the Department of Human services regarding resident #4
• On 05/15/2023 ED will monitor Call bell report from previous week and weekly thereafter. Call bell response time documentation to be kept in home.
• On 05/11/2023 an education was provided to all staff by the ED on Abuse regulation 2600.42.B and resident safety (Please see Exhibit-4.A) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 5/15/23).
• On [redacted]/2023 ED suspended staff persons responsible for resident #4, pending an investigation based on delayed call light response time.
• On [redacted]/2023 staff persons responsible for resident #4 care were terminated from the Community.
• On 05/15/2023 Rasp and Resident safety Interviews by ED or designee to take place 4 times weekly for 2 weeks followed by 2 times weekly for 2 weeks followed by 1 time weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit-4.B) (DIRECTED: Documentation of the interviews shall be kept. [redacted] 5/15/23).

DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23

42b - Abuse (continued)

Directed Completion Date: *06/12/2023*

Not Implemented [redacted] - 09/22/2023)

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/4/23 at approximately 1:00 PM, and on 3/7/23 at approximately 9:00 AM, resident #6's glucometer was used to test resident #3's blood glucose.

Plan of Correction ***Directed [redacted] 05/15/2023)***

• On 05/11/2023 resident #6's Glucometer was replaced with new device and resident MD notified of incident.
• On 05/11/2023 an audit of residents requiring Glucometers was completed by Designee (Please see Exhibit-5.A)
• On 05/11/2023 an Educations was given by ED to MedTechs on community Blood Glucose monitoring policy (attached) and regulation 2600.85.a (Please see Exhibit-5.B) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 5/15/23).
• An audit of all resident glucometers to occur 2 times weekly for 1 weeks followed by 1 time weekly for 2 weeks followed by 1 time biweekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month (Please see Exhibit-5.C) (DIRECTED: The audits of resident glucometers shall begin on 5/18/23. Documentation of the audits shall be kept. [redacted] 5/15/23)
DIRECTED; Beginning on 6/1/23: Documentation of the quality management reviews shall be kept. LM 5/15/23
• On 05/15/2023 ED or Designee shall observe 4 Med techs perform blood glucose checks weekly for 4 weeks to ensure proper procedures are followed. (Please Exhibit- 5.D) (DIRECTED: The audits shall rotate amongst staff persons to ensure all staff persons qualified to administer medications are observed. Documentation of the observations shall be kept. [redacted] 5/15/23).

Directed Completion Date: *06/12/2023*

Not Implemented [redacted] - 09/22/2023)

141a 1-10 Medical Evaluation Information

6. Requirements

2600.

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

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

Description of Violation

Resident #8's medical evaluation, signed by the medical professional on [redacted]/22, does not include the date resident #8 was evaluated or resident #8's height. These sections of the form are blank.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Accept [redacted] - 05/15/2023)***

• On 05/11/2023 Immediate action was taken to address resident #8's lacking DME information by Designee.
• On 05/11/2023 an Audit of all resident DME's by Designee checking for accuracy was completed. (Please see Exhibit-7.A)
• Resident check list
• On 05/11/2023 an education was provided to all resident admissions staff by ED regarding regulation 2600.141.a and proper/required evaluation information. (Please see Exhibit-7.B)
• On 05/15/2023 Audit for DME accuracy By ED or Designee to occur for 4 residents weekly for 2 weeks followed by 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month (Please see Exhibit-7.C)
• On 05/11/2023 an education was provided by ED or designee to all resident admissions staff on community move in check list (see attached) and responsibilities. (Please see Exhibit 7.D)

Licensee's Proposed Overall Completion Date: *06/22/2023*

Not Implemented [redacted] - 09/22/2023)

141b1 - Annual Medical Evaluation

7. Requirements

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

Description of Violation

Resident #5's most recent medical evaluation, signed by the medical professional on [redacted] 22, does not include the

141b1 - Annual Medical Evaluation (continued)

date resident #5 was evaluated or resident #5's height. These sections of the form are blank.

Resident #7's most recent medical evaluation, dated [redacted]/22, indicates "see attached" under the medication addendum section; however, nothing is attached to the medical evaluation. Resident #7 is prescribed numerous medications, including Levothyroxine-100 mcg and Melatonin-10 mg.

Resident #9's most recent medical evaluation, signed by the medical professional on [redacted]/22, does not include the date resident #9 was evaluated or resident #9's blood pressure, height, weight, pulse rate or temperature. These sections of the form are blank.

REPEAT VIOLATION: 12/28/2022; 8/30/2022, et. al.; 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/11/2023 resident #5, #7, and #9's DME was returned to resident MD requesting missing information by Designee. (DIRECTED: By 5/25/23: Copies of the updated medical evaluations for residents #5, #7 and #9 shall be kept in each resident's record. [redacted] 5/15/23).
• On 05/11/2023 an Audit of all resident DME's by Designee checking for accuracy was completed. (Please see Exhibit-7.A)
• On 05/11/2023 an education was provided to all resident admissions staff by ED regarding regulation 2600.141.b.1/Annual medical evaluation requirements. (Please see Exhibit-8.A)
• Audit for DME accuracy to occur for 4 residents weekly for 2 weeks followed by 2 residents weekly for 2 weeks followed b 1 resident weekly for 2 weeks. Ong Ongoing measure to be determined at monthly QA meeting held first Thursday of each month (Exhibit-7.C) (DIRECTED: The weekly audits shall begin on 5/18/23. [redacted] 5/15/23).
• On 05/17/2023 a Resident DME date tracker was created. (Please see Exhibit-8.B)
• On 5/22/2023 Tracking system to be monitored 1 time weekly for 4 weeks followed by 1 time monthly thereafter. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit-8.C) (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23).

Directed Completion Date: *06/01/2023*

Not Implemented ([redacted] - 09/22/2023)

183e - Storing Medications

8. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 3/24/23, there were 2 loose pills and an unknown white powder on the bottom of the left-bottom medication drawer in the MC1 medication cart.

On 3/23/23, resident #6's Levemir insulin pen was open and undated. According to the manufacturer's instructions, the insulin is to be discarded within 42 days of opening.

183e - Storing Medications *(continued)*

Plan of Correction ***Accept [redacted] - 05/15/2023)***

• On 05/05/2023 all Carts were checked for tidiness and any loose or unpackaged and unidentifiable medications were destroyed.

• On 05/11/2023 a Medication Cart Audit was completed for all carts within community by Designee. (Exhibit-9.A)

• On 05/11/2023 resident number #6's undated Levemir was discarded, Family and MD notified.

• On 05/11/2023 an education was given to Medtechs by ED regarding community medication storage policy, Medication Cart Audit tool, and Regulation 2600.183.E. Documentation of education will be kept. (Please see Exhibit-9.B)

• On 05/15/2023 Medication Cart Audits to be performed for all carts by ED or designee, 2 times weekly for 2 weeks followed by 1 time weekly for 2 weeks followed by 1 time biweekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Exhibit-9.C)

Licensee's Proposed Overall Completion Date: *06/22/2023*

Not Implemented [redacted] - 09/22/2023)

184a - Resident's Meds Labeled

9. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

On 3/22/23, there was no pharmacy label present on resident #6's Levemir 100U/ml insulin pen.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 04/29/2023 resident number #6's undated Levemir was discarded, Family and MD notified. Current Levemir properly labeled.

• On 05/11/2023 an education on community "Medication storage standards" (See attached) was given by ED to all Medtech and HWD staff. (Please see Exhibit-9.B)

• On 05/11/2023 and education on community "medication administration records policy" (see attached) was given by ED to all Medtech and HWD Staff. (Exhibit-10.A)

• Education documentation will be kept

• On 05/11/2023 an audit of all resident MAR's was completed by Designee. Proper labeling questioned in audit (Please see Exhibit-10.B)

• On 5/15/2023, Medication Administration records audit to be completed by ED or designee for 4 residents weekly for 2 weeks followed by 2 residents for 2 weeks followed by 1 resident for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 10-C) (DIRECTED: The weekly medication administration record audits shall also include a review of the medication pharmacy labels for the residents selected to ensure each medication includes an accurate and complete pharmacy label in accordance

184a - Resident's Meds Labeled (continued)

with 2600.184a. [redacted] 5/15/23).

DIRECTED: Beginning 6/1/23: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23

Directed Completion Date: *06/12/2023*

Not Implemented [redacted] - 09/22/2023)

185a - Implement Storage Procedures

10. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 3/22/23, resident #3's glucometer was not set on the current date and time.

Resident #5 is prescribed Risperidone 0.5 mg tablet–Take 1 tablet by mouth twice a day as needed for agitation; however, on 3/24/23, this medication was not available in the home for administration.

On 3/22/23, resident #6's glucometer was not set to the current time.

On 3/17/23 at approximately 7:00 AM, resident #6's blood glucose was 176; however, was documented as 178 on resident #6's March 2023 medication administration record (MAR).

REPEAT VIOLATION: 12/28/2022

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/11/2023 an audit of residents requiring Glucometers was completed by Designee (Exhibit-5.A)
• On 05/11/2023 an education was given by ED to MedTechs on community "Blood Glucose monitoring policy" (see attached) (Exhibit-5.B)
• On 05/11/2023 an education on community "Medication storage standards" see attached was given by ED to all Medtech and HWD staff. (Exhibit-9.B) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 5/15/23).
• On 05/10/2023 omitted medication for resident #5 was reported retroactively to DHS by ED
• On 05/10/2023 Family and MD notified by Designee of possible medication omission on 3/22/23 medication ordered and submitted to pharmacy.
• On 05/11/2023 an education on "Medication Policy" (See attached) was given by ED to all Medtech and HWD Staff to ensure required medication is ordered properly and available. (Please see Exhibit-11.A) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 5/15/23).
• On 5/15/2023, Medication Administration records audit to be completed by ED or designee for 4 residents weekly for 2 weeks followed by 2 residents for 2 weeks followed by 1 resident for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 10-C) (DIRECTED: The weekly medication administration record audits shall also include a review of all current medications for the residents selected to ensure each prescribed medication is present in the home and available for administration. The audits shall also include a review of blood sugar readings and documentation to ensure accurate blood sugar

185a - Implement Storage Procedures (continued)

documentation. Documentation of the audits shall be kept. [redacted] 5/15/23).

DIRECTED: Within 24 hours of receipt of the plan of correction: Resident #5's Risperidone shall be present in the home and available for administration in accordance with prescriber's orders. [redacted] 5/15/23

DIRECTED: Beginning 6/1/23: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23

Directed Completion Date: *06/12/2023*

Not Implemented ([redacted] - 09/22/2023)

185b - Medication Procedures

11. Requirements

2600.
185.b. At a minimum, the procedures must include:
2. A process to investigate and account for missing medications and medication errors.

Description of Violation

The home's Controlled Medication Management Policy states, "A narcotic count will be completed at the change of every shift or when custody of the keys changes.....upon completion of the narcotic count verification, both employees will sign the Narcotic Count Verification Form." However, on numerous dates and times, to include the following, staff persons did not sign the Narcotic Count Verification Form after counting the controlled substances at the change of shift:

- *No staff persons initialed the verification form at the start of the daylight shift on 3/1/23, 3/4/23, 3/6/23, 3/7/23, 3/9/23, 3/10/23, 3/11/23, 3/12/23, 3/14/23, 3/18/23 and 3/19/23*
- *No staff persons initialed the verification form at the start of the evening shift on 3/4/23, 3/5/23, 3/14/23, 3/18/23, 3/19/23, 3/21/23 and 3/22/23*
- *No staff persons initialed the verification form at the start of the night shift daily from 3/1/23 through 3/12/23 and 3/14/23 through 3/20/23*

Plan of Correction ***Accept ([redacted] - 05/15/2023)***

• On 05/11/2023 an audit of the narcotics count sheet and their contents was completed by Designee checking for accuracy and timeliness. (Please see Exhibit-12.A)
• On 05/11/2023 an education was given by ED to Medtech Staff on "community Controlled medication management policy"(See attached). (Exhibit-12.B)
• Documentation of education will be kept.
• On 05/15/2023 an Audit of proper change of shift narcotic count by Designee to be completed 4 times weekly for 2 weeks followed by 2 times weekly for 2 weeks followed by 1 time weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Exhibit-12.C)

Licensee's Proposed Overall Completion Date: *06/22/2023*

Not Implemented ([redacted] - 09/22/2023)

186b - Medication Used by Resident

12. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

Resident #10 is prescribed Tramadol HCL 50 mg tablet-Take 1/2 tablet (25 mg) by mouth every 8 hours. On 2/28/23, no Tramadol was present in the home for resident #10, so resident #10 was administered resident #11's Tramadol tablets.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/05/2023 immediate action was taken to investigate medtech responsible for administering resident #11's medication to resident #10 by ED.
• On 05/11/2023 and education on "Medication Policy" (See attached) was given by ED to all Medtech and HWD Staff to ensure required medication is ordered properly. (Exhibit-11.A)
• Documentation of education to be kept.
• On 5/15/2023, Medication Administration records audit to be completed by ED or designee to ensure all medications for resident are present in the home for 4 residents weekly for 2 weeks followed by 2 residents for 2 weeks followed by 1 resident for 2 weeks. (DIRECTED: The weekly medication administration record audits shall also include a review of all current medications for the residents selected to ensure each prescribed medication is present in the home and available for administration. Documentation of the audits shall be kept. [redacted] 5/15/23). Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 10-C) (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23).

Directed Completion Date: *06/12/2023*

Not Implemented [redacted] - 09/22/2023)

187a - Medication Record

13. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #2 is prescribed Acetaminophen 500 mg tablet-Take 2 tablets by mouth daily in the morning; however, resident #2's March 2023 MAR indicates Acetaminophen 500 mg tablet-Take 1 tablet by mouth once daily at 7:00 AM.

187a - Medication Record (continued)

Resident #2 is prescribed Calcium Carbonate 600 mg tablet-Take 1 tablet by mouth once daily; however, resident #2's March 2023 MAR indicates Calcium Citrate 200 mg tablet-Take 3 tablets by mouth once daily.

Resident #2 is prescribed Donepezil 5 mg tablet–Take 1 tablet by mouth every morning; however, resident #2's March 2023 MAR indicates Donepezil 10 mg-Take 1 tablet by mouth once daily.

Resident #2 is prescribed Simvastatin 40 mg tablet–Take 1 tablet by mouth at bedtime; however, resident #2's March 2023 MAR indicates Simvastatin 10 mg tablet–Take 1 tablet by mouth daily at 7:00 PM.

Resident #2 is prescribed Vitamin B-12 1000 mcg tablet–Take 1 tablet by mouth once daily; however, resident #2's March 2023 MAR indicates Vitamin B-12 500 mcg tablet–Take 1 tablet by mouth once daily.

Resident #2 is prescribed Famotidine 20 mg tablet–Take 1 tablet by mouth daily before a meal; however, resident #2's March 2023 MAR indicates Famotidine 10 mg tablet-Take 1 tablet by mouth once daily at 3:00 PM.

Resident #2 is prescribed the following medications, which are not present on resident #2's March 2023 MAR:

- *Aspirin EC 81 mg tablet–Take 1 tablet by mouth once daily*
- *Carbamide Peroxide 6.5%-Instill 5 drops in the right ear twice daily*
- *Fish Oil/Omega 3/Vitamin C 280 mg–850 mg/2.5 g tablet-Take 1 tablet by mouth once daily*

Resident #6's March 2023 MAR does not include a diagnosis or purpose for Acetaminophen 500mg-Take 2 caplets by mouth twice daily.

Plan of Correction ***Directed ([redacted] - 05/15/2023)***

• On 05/11/2023 immediate action was taken by Designee to correct all discrepancies in resident #2' MAR.
• On 05/11/2023 Immediate action was taken by designee to update resident #6's diagnosis or purpose for prescribed medication.
• On 05/11/2023 and education on "Medication Policy" (See attached) was given by ED to all Medtech and HWD Staff to ensure required medication record keeping. (Please see Exhibit-11.A)
• Documentation of education will be kept.
• On 05/15/2023 all Resident Mar's audited by ED or Designee for accuracy. (Please see Exhibit-10.B)
• On 5/15/2023, Medication Administration records audit to be completed by ED or designee to ensure all medications for resident are present in the home for 4 residents weekly for 2 weeks followed by 2 residents for 2 weeks followed by 1 resident for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 10-C) (DIRECTED: The audits shall also include a review of each resident's medication administration record for the residents selected to ensure each resident has an accurate and complete medication administration record in accordance with 2600.187a. Documentation of the audits shall be kept. [redacted] 5/15/23).

DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23

Directed Completion Date: *06/12/2023*

187a - Medication Record *(continued)*

Not Implemented [redacted] - 09/22/2023)

187b - Date/Time of Medication Admin.

14. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2's March 2023 MAR does not include the initials of the staff person who administered resident #2's Bupropion HCL SR-150 mg to resident #2 on 3/20/23 at 3:00 PM.

Resident #5's March 2023 MAR does not include the initials of the staff person who administered resident #5's Refresh Tear Drops-5% to resident #5 on 3/3/23 and 3/17/23 at 8:00 PM.

Resident #6 is prescribed Gabapentin 300 mg capsule –Take 1 capsule by mouth 2 times a day. This medication is administered to resident #6 at 8:00 AM and 8:00 PM daily; however, resident #6's March 2023 MAR indicates this medication was administered at 7:00 AM and 3:00 PM daily from 3/1/23 through 3/21/23.

Resident #6 is prescribed Acetaminophen 500 mg–Take 1 caplet by mouth twice a day. This medication is administered to resident #6 at 8:00 AM and 8:00 PM daily; however, resident #6's March 2023 MAR indicates this medication was administered at 8:00 AM and 3:00 PM daily from 3/1/23 through 3/21/23.

Resident #9's March 2023 MAR does not include the initials of the staff person who administered resident #9's Diclofenac Sodium-1% gel to resident #9 on 3/6/23 at 5:00 PM and on 3/8/23 and 3/19/23 at 9:00 PM.

Resident #9 is prescribed Hydrocodone/APAP 5mg/325 mg tablet–Take 1 tablet by mouth every 6 hours as needed for pain. On numerous dates and times, to include the following, staff persons did not document the medication administration on resident #9's March 2023 MAR at the time of medication administration:

Date and time administered	***Time Documented on resident #9's March 2023 MAR***
• *3/4/23 at 4:00 PM*	*7:43 PM*
• *3/5/23 at 3:00 PM*	*9:47 PM*
• *3/8/23 at 3:00 PM*	*6:51 PM*
• *3/18/23 at 12:00 PM*	*6:14 PM*
• *3/21/23 at 6:30 AM*	*7:29 AM*
• *3/21/23 at 2:00 PM*	*5:17 PM*

Resident #10's March 2023 MAR does not include the initials of the staff person who administered resident #10's Tramadol-25 mg tablet to resident #10 on 3/15/23 at 2:00 PM, 3/25/23 at 6:00 AM and on 3/22/23 and 3/29/23 at 10:00 PM.

Resident #12's March 2023 MAR does not include the initials of the staff person who administered resident #12's Eliquis-5 mg tablet to resident #12 on 3/6/23 at 5:00 PM.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/11/2023 an education was provided by ED to Medtech and HWD staff on regulation 2600.187.B.

187b - Date/Time of Medication Admin. (continued)

Medications administered in their proper time windows, Proper documentation of medications given. (Please see Exhibit-15.A)

• On 05/11/2023 and education on "Medication Policy" (See attached) was given by ED to all Medtech and HWD Staff to ensure required medication record keeping. (Please see Exhibit-11.A)

• Documentation of education to be kept

• Medication policy not followed by staff. Carts not being brought directly to room resulted in forgetfulness of documentation.

• On 5/15/2023, Medication Administration records audit to be completed by ED or designee to ensure all medications for resident reflet MD orders for 4 residents weekly for 2 weeks followed by 2 residents for 2 weeks followed by 1 resident for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 10-C) (DIRECTED: The weekly audits of resident medication administration records shall include ensuring staff persons have initialed resident medication administration records at the time of medication administration. Documentation of the audits shall be kept. [redacted] 5/15/23)

DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23

Directed Completion Date: *06/12/2023*

Not Implemented [redacted] - 09/22/2023)

187d - Follow Prescriber's Orders

15. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed Cholecalciferol 25 mcg-Take 1 tablet by mouth once daily; however, this medication was not administered to resident #2 from 3/1/23 to 3/21/23, because it was not available in the home for administration.

From approximately 2/1/23 through 3/22/23, resident #2 did not receive the following medications, because they were not available in the home for administration:

- *Aspirin EC 81 mg tablet–Take 1 tablet by mouth once daily*
- *Carbamide Peroxide 6.5%-Instill 5 drops in the right ear twice daily*
- *Fish Oil/Omega 3/Vitamin C 280 mg–850 mg/2.5 g tablet–Take 1 tablet by mouth once daily*
- *Buspirone 5 mg tablet–Take 1 tablet by mouth twice a day*

Numerous medications were not administered to resident #3 on numerous dates and times, to include the following:

- *Aspirin 81 mg tablet–Take 1 tablet by mouth once daily. Not administered on 3/11/23*
- *Escitalopram 20 mg tablet–Take 1 tablet by mouth once daily. Not administered on 3/11/23*
- *Carvedilol 25 mg tablet–Take 1 tablet by mouth twice daily. Not administered on 3/10/23 at 3:00 PM or on 3/11/23 at 7:00 AM*
- *Gabapentin 100 mg capsule–Take 1 capsule by mouth 3 times daily. Not administered on 3/11/23 at 7:00 AM*
- *Pantoprazole Sodium 40 mg tablet–Take 1 tablet by mouth twice daily. Not administered on 3/10/23 at 3:00 PM or on 3/11/23 at 7:00 AM.*

187d - Follow Prescriber's Orders (continued)

- Metoclopramide HCL 10 mg tablet–Take 1 tablet by mouth 3 times a day. Not administered on 3/11/23 at 7:00 AM or 11:00 AM

Resident #10 is prescribed Tramadol 50 mg tablet–Take ½ tablet (25 mg) by mouth every 8 hours. This medication was not administered to resident #10 on 3/1/23 at 6:00 AM or on 3/1/23 at 2:00 PM, because it was not available in the home for administration.

Resident #12 is prescribed Fexofenadine 180 mg tablet–Take 1 tablet by mouth once daily; however, this medication was not administered to resident #12 on numerous dates, to include on 3/2/23, 3/3/23, 3/6/23, 3/7/23, and 3/9/23.

Resident #12 is prescribed Furosemide 20 mg tablet–Take 1 tablet by mouth every-other-day; however, this medication was not administered to resident #12 on 3/2/23, because it was not available in the home for administration.

Resident #12 is prescribed Metoprolol 25 mg tablet–Take ½ tablet (12.5 mg) by mouth twice a day; however, this medication was not administered to resident #12 on 3/2/23 at 5:00 PM.

REPEAT VIOLATION: 12/28/2022; 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/05/2023 Action was taken by Executive Director to properly report all medication errors listed retro actively to the department of human services.
• On 05/11/2023 and education on "Medication Policy" (See attached) was given by ED to all Medtech and HWD Staff to ensure medication availability and reorder process. (Exhibit-11.A) Documentation of education to be kept.
• On 05/11/2023 Medication administration records audits were performed for listed residents to check for accuracy by ED of Designee. (Exhibit-16.
• On 05/15/2023 all Resident Mar's audited by ED or Designee for accuracy. (Please see Exhibit-10.B)
• On 5/15/2023 Medication overflow cart removed from use. (Cart was used to store extra medications for residents which often caused confusion of staff by way of medication availabilities.)
• On 5/15/2023, Medication Administration records audit Checking for medication availability to be completed by ED or designee to ensure all medications for residents reflet MD orders for 4 residents weekly for 2 weeks followed by 2 residents for 2 weeks followed by 1 resident for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 10-C) (DIRECTED: The weekly medication administration record audits shall also include a review of all current medications for the residents selected to ensure each prescribed medication is present in the home and available for administration. Immediately following the weekly audits, monthly audits shall be performed for at least 5 residents per month. Documentation of the audits shall be kept. [redacted] 5/15/23)

DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept.[redacted] 5/15/23

DIRECTED: BY 5/22/23: The administrator shall review all medications for residents #2, #3, #10 and #12 to ensure all prescribed medications are present in the home and available for administration. [redacted] 5/15/23

Directed Completion Date: 06/12/2023

Not Implemented [redacted] - 09/22/2023)

225c - Additional Assessment

16. Requirements

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

Description of Violation

Resident #5's most recent medical evaluation, signed by the medical professional on [redacted]/22, includes the diagnoses of Edema, Dermatitis and Excoriation of the skin; however, these diagnoses are not indicated on resident #5's most recent assessment, dated [redacted]/23.

Resident #9's most recent assessment, dated [redacted]/22, does not include resident #9's supervision needs. This section of resident #9's assessment is blank.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/11/2023 immediate action was taken by ED or Designee to reassess resident #5 and resident #9 properly to reflect current diagnoses and supervisory needs.
• On 05/11/2023 all new residents of the last 30 days assessments were audited to check for accuracy by ED or designee. (Please see Exhibit-17.A)
• On 5/16/2023 all resident assessments audited for accuracy by ED or Designee to determine assessment and due dates. (Please see Esxhibit-17.D)
• Late assessments due to high HWD turn over. On 05/15/2023 Excel spreadsheet created to track all assessment dates and upcoming due dates and monitored by ED or designee monthly. (Please See Exhibit-17.E) (DIRECTED: The monthly audits of the tracking system shall begin on 6/1/23. [redacted] 5/15/23).
• On 05/11/2023 an education was provided to HWD director and administrative staff on regulation 2600.225. resident annual assessment accuracy and timeliness. (Please see Exhibit-17.B)
• Documentation of education will be kept.
• On 05/15/2023 An audit of resident assessments and their dates to be completed by ED or Designee for 5 residents weekly for 2 weeks followed by 4 residents weekly for 2 weeks followed by 2 residents weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit-17.C) (DIRECTED: Immediately following the weekly audits, monthly audits shall be performed for at least 5 residents to ensure each resident has an assessment completed in its entirety at least annually.[redacted] 5/15/23).

DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23

Directed Completion Date: *06/12/2023*

Not Implemented [redacted] - 09/22/2023)

227d - Support Plan Medical/Dental

17. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #4's most recent assessment, dated 9/19/22, indicates resident #4 requires some physical assistance with personal hygiene; however, resident #4's most recent support plan, dated 9/19/22, does not indicate the description or plan to meet this service need. This section of resident #4's support plan is blank.

Resident #5 is currently receiving hospice services approximately 3 times a week; however, these services are not indicated on resident #5's most recent support plan, dated 3/21/23.

REPEAT VIOLATION: 8/30/2022, et. al.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/11/2023 immediate action was taken by ED or designee to accurately reflect resident #4 and #5's current assessed needs in their most recent support plan.
• On 05/11/2023 an audit was completed of all resident support plans by ED or designee to determine support plan accuracy. (Please see Exhibit-18.A)
• On 05/11/2023 an education was provided by ED to Administration and HWD on "Individualized service plan policy" (Please see Exhibit-18.B)
• Support plan discrepancy due to large exit of care staff at once. New HWD and Medical records clerk hired. Training for support plan and assessment process provided on 05/11/2023 to HWD and MRC by ED, medical records clerk to double check assessment and support plan to verify accuracy after completed by HWD. (Please see Exhibit-18.D)
• Documentation of education to be Kept
• On 05/15/2023 An audit of resident support plans be completed by ED or designee for 5 residents weekly for 2 weeks followed by 4 residents weekly for 2 weeks followed by 2 resident weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit-18.C) (DIRECTED: Immediately following the weekly audits, monthly audits shall be performed for at least 5 residents to ensure each resident has an accurate support plan which indicates the resident's needs. [redacted] 5/15/23).

DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23

Directed Completion Date: *06/12/2023*

Not Implemented ([redacted] - 09/22/2023)

231b - Medical Evaluation

18. Requirements

2600.

231b - Medical Evaluation *(continued)*

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #5 resides in the secured dementia care unit (SDCU); however, resident #5's most recent medical evaluation, signed by the medical professional on [redacted]22, does not indicate the need for resident #5 to be served in the SDCU.

Resident #8 was admitted to the SDCU on [redacted]22; however, resident #8's medical evaluation does not include the date resident #8 was evaluated, so it is unable to be determined if resident #8's medical evaluation was completed within 60 days prior to admission. Also, resident #8's medical evaluation does not indicate the need for resident #8 to be served in the SDCU.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/16/2023 action taken by ED or designee to update resident #5 and resident #8's evaluation to reflect SDCU needs, Updated DME from MD received by Designee to reflect SDCU needs.
• Documentation of evaluation will be kept.
• On 05/11/2023 an audit of DME for all residents residing in SDCU completed by ED or designee to reflect SDCU needs. (Exhibit-19.A)
• On 05/11/2023 an education was provided to Memory Care Director and Memory Care Coordinator by ED regarding regulation 2600.231.b and the need of a resident for a secured unit. (Exhibit-19.B)
• On 05/11/2023 an education was provided by ED or designee to all resident admissions staff on community move in check list (see attached) and responsibilities. (Please see Exhibit 7.D)
• Documentation of educations to be kept.
• 05/15/2023 Audit by ED or Designee for DME accuracy to occur for 4 residents weekly for 2 weeks followed by 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Exhibit-7.C)

DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept. [redacted] 5/15/23

Directed Completion Date: *06/12/2023*

Not Implemented [redacted] - 09/22/2023)

234a - Admission Support Plan

19. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #7 was admitted to the SDCU on [redacted]22; however, resident #7's initial support plan was not completed

234a - Admission Support Plan (continued)

until [redacted]22, and was not signed by the assessor as completed until [redacted]/22.

Resident #8 was admitted to the SDCU on [redacted]22; however, resident #8's support plan is undated, so it is unable to be determined if it was completed within 72 hours of admission or within 72 hours prior to admission.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 05/15/2023)***

• On 05/16/2023 Action taken by ED or Designee to update resident #7's support plan to reflect accurate information.
• On 05/11/2023 immediate action was taken by ED or designee to update resident #8's support plan to reflect accurate information.
• On 05/11/2023 an audit was completed of all resident support plans by ED or designee to determine support plan accuracy. (Exhibit-18.A)
• On 05/11/2023 an education was provided by ED to Administration and HWD on Individualized service plan policy (Exhibit-18.B)
• Documentation of education shall be kept.
• on 05/11/2023 an Education was provided by ED to Memory Care Director and Memory Care Coordinator on regulation 2600.234.a (Exhibit-20.A)
• On 05/11/2023 an education was provided by ED or designee to all resident admissions staff on community move in check list (see attached) and responsibilities. (Please see Exhibit 7.D)
• On 05/15/2023 A support plan audit to be completed By ED or designee for 4 residents in SDCU weekly for 2 weeks, followed by 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Exhibit-20.B)

DIRECTED: Beginning on 6/1/23: Documentation of the quality management reviews shall be kept. [redacted]5/15/23

Directed Completion Date: *06/12/2023*

Not Implemented [redacted] - 09/22/2023)

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

Facility Information

Name: *THE SHERIDAN AT BETHEL PARK* **License #:** *44948* **License Expiration:** *10/14/2023*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA 15234*

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

Administrator

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

Legal Entity

Name: *KJ BETHEL PARK LLC*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA, 15234*

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *12/13/2018* **Issued By:** *Municipality of Bethel Park*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *174* **Waking Staff:** *131*

Inspection Information

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

Reason: *Complaint, Fine* **Exit Conference Date:** *05/19/2023*

Inspection Dates and Department Representative

05/03/2023 - On-Site: [redacted]

05/04/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* **Residents Served:** *116*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *MC 1 and MC2* **Capacity:** *40* **Residents Served:** *35*

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *116*

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

Have Mobility Need: *58* **Have Physical Disability:** *0*

Inspections / Reviews

05/03/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/01/2023*

06/08/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/06/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/14/2023*

06/16/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/06/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/06/2023*

09/22/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/06/2023*

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

25b - Contract Signatures

1. 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

Resident #5's resident-home contract, dated [redacted]/22, is not signed by the resident.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed ([redacted] - 06/16/2023)***

• Immediate action was taken by Executive Director on 5/03/2023 to have resident #5 sign residency agreement.
• On 4/30/2023 all contracts were audited for accuracy By Designee. It was found that all contracts were in compliance with the exception of resident #5. Resident #5 was out of the community with family at the time of contract audit.
• An education to be provided by ED on 6/05/2023 to admissions staff regarding regulation 2600.25.b as it pertains to resident signatures. (Exhibit 1.A) Documentation of education to be kept.
• Beginning 6/05/2023, An audit of all residency agreements in community to be completed by Designee of 4 residents weekly for 2 weeks followed by 4 resident biweekly for 2 weeks followed by 2 residents biweekly for 2 weeks. On going measures to be determined at monthly QA meeting held first Thursday of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 6/16/23).
Resident Check list to be utilized at time of move in for all new residents. (Exhibit 7. D) (DIRECTED: Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 6/16/23).
on 5/11/2023 Education on new move in check list provided by ED to admission staff.

Directed Completion Date: *07/06/2023*

Not Implemented [redacted] - 09/22/2023)

53c - Administrator Duties

2. Requirements

2600.
53.c. The administrator shall be responsible for the administration and management of the home, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter.

Description of Violation

Numerous staff persons indicated that some time in March 2023, staff person A arrived at the home for [redacted] shift and appeared to be under the influence of alcohol and vomited in the home's secure dementia care unit (SDCU). Staff person A had to be escorted home. Also, staff persons indicated there have been numerous occasions where they have disposed of other staff person cups from staff break areas that appeared to contain alcohol.

53c - Administrator Duties *(continued)*

Plan of Correction ***Directed [redacted] - 06/16/2023)***

•• On 5/29/2023 An education was provided by ED to staff on company substance abuse policy (Exhiit 2.A)
• On 6/4/2023 an education was provided to staff person A specifically regarding the substance abuse policy and call out procedure.
• Shift Supervisors rounding community every other hour. (DIRECTED: The hourly rounds conducted by shift supervisors shall begin on 6/18/23. [redacted] 6/16/23).
• Documentation of Education to be kept.
• On 05/29/2023 Company substance abuse policy posted in employee breakroom and Care team rooms.
• On 6/1/2023 Substance abuse policy to be discussed weekly at morning stand up for 4 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month.

Directed Completion Date: *06/18/2023*

Not Implemented[redacted] - 09/22/2023)

141a - Medical Evaluation

3. 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's medical evaluation, dated [redacted] /23, does not include resident #2's allergies. This section of the evaluation is blank.

Resident #6's medical evaluation, dated [redacted] /22, does not include resident's #6's immunization history. This section of the evaluation is blank.

Resident #7's medical evaluation, dated [redacted] /22, does not include resident #7's body positioning/movement needs. This section of the evaluation is blank.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 06/16/2023)***

• On 05/11/2023 an Audit of all resident DME's by Designee checking for accuracy was completed. (Please see Exhibit-7.A)
• On 05/11/2023 an education was provided to all resident admissions staff by ED regarding regulation 2600.141.a and proper/required evaluation information. (Please see Exhibit-7.B)
on 5/11/2023 Resident #2, #6, and #7 DME updated with missing information by HWD, and resident PCP.
• On 05/15/2023 Audit for DME accuracy By ED or Designee to occur for 4 residents weekly for 2 weeks followed by 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month (Please see Exhibit-7.C) (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 6/16/23).

141a - Medical Evaluation (continued)

on 5/11/2023, New move in check list to be utilized at all time of move in for new residents. (Exhibit 7.D) (DIRECTED: Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 6/16/23).

•On 05/11/2023 an education was provided by ED or designee to all resident admissions staff on community move in check list (see attached) and responsibilities. (Please see Exhibit 7.D) (DIRECTED: Documentation of the education shall be kept. [redacted] 6/16/23).

Directed Completion Date: *07/06/2023*

Not Implemented [redacted] - 09/22/2023)

144c1 - Smoking Area Guidelines

4. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's smoking policy indicates, "smoking is prohibited on the entire premise, including inside residential units, all common areas and areas within thirty (30) feet of entrances, windows, doors and air-intake units, by all persons....'Smoking' means inhaling, exhaling, burning or carrying any lighted cigar, cigarette, pipe or any form of lighted object or device that contains tobacco, to include but not limited to electronic cigarettes and vaping"; however, according to numerous staff persons, staff persons are vaping regularly in the home, including in the care aide rooms.

Plan of Correction ***Directed [redacted] - 06/16/2023)***

• On 5/29/2023 An education was provided by ED to staff on company Smoking Policy (Exhiit 4.A) Documentation of Education to be kept.

• On 05/29/2023 Company smoking policy posted in employee breakroom and Care team rooms.
Starting 6/10/2023 Community Supervisors to round community hourly checking for employee misconduct and resident safety concerns.

• On 6/1/2023 Smoking policy to be discussed weekly at morning stand up for 4 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 6/16/23).

Directed Completion Date: *07/06/2023*

Not Implemented [redacted] - 09/22/2023)

183d - Prescription Current

5. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #10 was prescribed Coricidin HBP 200/100mg capsule-Take 1 capsule by mouth every 8 hours as needed. This medication was discontinued by the prescriber on 12/15/22; however, was still present in the home on 5/3/23.

Resident #10 was prescribed Mucinex Cough 200 mg capsule-Take 1 capsule by mouth every 6 hours as needed. This medication was discontinued by the prescriber on 12/15/22; however, was still present in the home on 5/3/23.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Accept [redacted] - 06/08/2023)***

• On 05/05/2023 all Carts were checked for tidiness and any loose or unpackaged and unidentifiable medications were destroyed including resident #10's unused meds.
• On 05/11/2023 a Medication Cart Audit was completed for all carts within community by Designee. (Exhibit-9.A)
• On 05/11/2023 an education was given to Medtechs by ED regarding community medication storage policy, Medication Cart Audit tool, and Regulation 2600.183.E. Documentation of education will be kept. (Please see Exhibit-9.B)
• On 05/15/2023 Medication Cart Audits to be performed for all carts by ED or designee, 2 times weekly for 2 weeks followed by 1 time weekly for 2 weeks followed by 1 time biweekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Exhibit-9.C)

Licensee's Proposed Overall Completion Date: *07/28/2023*

Not Implemented[redacted] - 09/22/2023)

186a - Authorized Prescriber

6. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

On 5/3/23, a copy of the current physician order, or a copy of the discontinued order for resident #5's Morphine were not present in the home. According to the home, resident #5's Morphine was discontinued.

On 5/3/23, copies of the current physician orders for resident #5's Hyoscyamine Sulfate 0.125 mg and Haloperidol 2mg/ml were not present in the home.

On 5/3/23, copies of the current physician orders for resident #10's Guaifenesin 100mg/5ml cough syrup and Fluticasone Nose Spray were not present in the home.

186a - Authorized Prescriber (continued)

Plan of Correction ***Directed [redacted] - 06/16/2023)***

• On 05/29/2023 the HWD or Designee contacted resident MD's to obtain and update orders for resident #5 and #10 to reflect the accurate needs of the resident.
• On 05/11/2023 and education on "Medication Policy" (See attached) was given by ED to all Medtech and HWD Staff to ensure required medication is ordered properly based on Community and Pharmacy policy for timely ordering. (Exhibit-11.A)
• Documentation of education to be kept.
on 6/01/2023 All residents Charts were audited to determine prescriber order accuracy in the home by HWD or designee. 6.A
• On 6/14/2023, Prescriber orders audit to be completed by ED or designee to ensure all medications for resident are present in the home for 4 residents weekly for 2 weeks followed by 2 residents for 2 weeks followed by 1 resident for 2 weeks (DIRECTED: The weekly audits shall also include a review of resident prescriber's orders to ensure copies of current prescriber's orders are present in the home. [redacted] 6/16/23). Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 6.C
• Documentation of quality management reviews shall be kept.

Directed Completion Date: *07/06/2023*

Not Implemented [redacted] - 09/22/2023)

187b - Date/Time of Medication Admin.

7. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is prescribed Levothyroxine 88 mcg tablet-Take 1 tablet by mouth every morning; however, this medication was not documented as administered on resident #2's April 2023 medication administration record (MAR) on 4/12/23.

The following medications were not documented as administered on resident #3's April 2023 MAR at 5:00 pm on 4/21/23:

- *Acetaminophen 325 mg tablets-Take 2 tablets by mouth twice a day*
- *Calcium/Vitamin D 600 mg tablet-Take 1 tablet by mouth twice a day*
- *Eliquis 2.5 mg tablet-Take 1 tablet by mouth twice a day*
- *Metoprolol Tartrate 25 mg tablet-Take 3 tablets by mouth twice a day*

Resident #4 is prescribed Carbidopa/Levodopa 25/100 mg tablet-Take 1 tablet by mouth twice a day; however, this medication was not documented as administered on resident #4's April 2023 MAR at 2:00 pm on 4/20/23.

Resident #4 is prescribed Carbidopa/Levodopa 25/250 mg tablet-Take 1 tablet by mouth 3 times a day; however this medication was not documented as administered on resident #4's April 2023 MAR at 6:00 am on 4/12/23.

Resident #4's April 2023 MAR indicates that staff person "SS" administered all of resident #4's 9:00 am medications

187b - Date/Time of Medication Admin. (continued)

on 4/7/23; however, all agency staff persons are sharing the same electronic MAR login credentials [redacted]", so it is unable to be determined which agency staff person is administering medications to residents.

Plan of Correction ***Accept [redacted] - 06/16/2023)***

• On 05/11/2023 an education was provided by ED to Medtech and HWD staff on regulation 2600.187.B. Medications administered in their proper time windows; Proper documentation of medications given. (Please see Exhibit-15.A)
• On 05/11/2023 and education on "Medication Policy" (See attached) was given by ED to all Medtech and HWD Staff to ensure required medication record keeping. (Please see Exhibit-11.A)
• Documentation of education to be kept
• Medication policy not followed by staff. Carts not being brought directly to room resulted in forgetfulness of documentation.
• On 5/15/2023, Medication Administration records audit to be completed by ED or designee to ensure all medications for resident reflect MD orders and are properly initialed at time of admin for 4 residents weekly for 2 weeks followed by 2 residents for 2 weeks followed by 1 resident for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 10-C)
• On 6/1/23 documentation of quality management reviews shall be kept.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Not Implemented [redacted] - 09/22/2023)

187d - Follow Prescriber's Orders

8. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is prescribed Donepezil HCL 5mg tablet-Take 1 tablet by mouth at bedtime; however, this medication was not administered to resident #1 on 5/1/23 and 5/2/23, because the medication was not available in the home for administration.

Resident #1 is prescribed Atorvastatin 20 mg tablet-Take 1 tablet by mouth once a day; however, this medication was not administered to resident #1 on 5/1/23 and 5/2/23, because the medication was not available in the home for administration.

The following medications were not administered to resident #3 at 5:00 pm on 4/21/23:

- *Acetaminophen 325 mg tablets-Take 2 tablets by mouth twice a day*
- *Calcium/Vitamin D 600 mg tablet-Take 1 tablet by mouth twice a day*
- *Eliquis 2.5 mg tablet-Take 1 tablet by mouth twice a day*
- *Metoprolol Tartrate 25 mg tablet-Take 3 tablets by mouth twice a day*

Resident #4 is prescribed Aspirin 81 mg tablet-Take 1 tablet by mouth once a day; however, this medication was not administered to resident #4 on 4/5/23 and 4/6/23, because the medication was not available in the home for administration.

187d - Follow Prescriber's Orders (continued)

Resident #4 is prescribed Carbidopa/Levodopa 25/100 mg tablet-Take 1 tablet by mouth twice a day; however, this medication was not administered to resident #4 at 8:00 am on 4/19/23 and 2:00 pm on 4/28/23, because the medication was not available in the home for administration.

Resident #4 is prescribed Carbidopa/Levodopa 25/250 mg tablet-Take 1 tablet by mouth 3 times a day; however, this medication was not administered to resident #4 at 12:00 pm on 4/22/23, because the medication was not available in the home for administration.

REPEAT VIOLATION: 12/28/2022; 8/1/2022, et. al.

Plan of Correction ***Accept (- 06/16/2023)***

• On 05/11/2023 and education on "Medication Policy" (See attached) was given by ED to all Medtech and HWD Staff to ensure medication availability and reorder process. (Exhibit-11.A) Documentation of education to be kept.
• On 05/15/2023 all Resident Mar's audited by ED or Designee for accuracy. (Please see Exhibit-10.B)
• On 5/15/2023 Medication overflow cart removed from use. (Cart was used to store extra medications for residents which often caused confusion of staff by way of medication availabilities.)
on 5/15/2
• On 5/15/2023, Medication Administration records and resident medication audit Checking for medication availability to be completed by ED or designee to ensure all medications for residents reflect MD orders for 6 residents weekly for 2 weeks followed by 3 residents weekly for 2 weeks followed by 2 resident weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit 10-C)
• On 6/01/2023 documentation of quality management reviews shall be kept.
• By 5/22/2023 The Administrator or Designee shall review all medications for resident #1 and #4 to ensure all prescribed medications are present in the home and available for administration. Medical records clerk to contact pharmacy and have any missing medications delivered same day.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Not Implemented - 09/22/2023)

227g -Support Plan Signatures

9. Requirements

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

Description of Violation

Resident #9's support plan, dated 23, is not signed by the assessor.

REPEAT VIOLATION: 12/28/2022; 8/1/2022, et. al.

Plan of Correction ***Accept - 06/08/2023)***

• On 5/29/2023 support plan was updated by Designee to accurately reflect correct assessor signature.
• On 5/29/2023 an education was provided staff tasked with Assessments in the community by ED

227g -Support Plan Signatures (continued)

• Documentation of educations kept.
• On 05/11/2023 an audit was completed of all resident support plans by ED or designee to determine support plan accuracy. (Please see Exhibit-18.A)
• On 05/11/2023 an education was provided by ED to Administration and HWD on "Individualized service plan policy" (Please see Exhibit-18.B)
• Support plan discrepancy due to large exit of care staff at once. New HWD and Medical records clerk hired. Training for support plan and assessment process provided on 05/11/2023 to HWD and MRC by ED, medical records clerk to double check assessment and support plan to verify accuracy after completed by HWD. (Please see Exhibit-18.D)
• On 05/15/2023 An audit of resident support plans be completed by ED or designee for 5 residents weekly for 2 weeks followed by 4 residents weekly for 2 weeks followed by 2 resident weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Please see Exhibit-18.C)

Licensee's Proposed Overall Completion Date: *07/28/2023*

Not Implemented [redacted] - 09/22/2023)

234a - Admission Support Plan

10. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #8 was admitted to the SDCU on [redacted]/22; however, resident #8's initial support plan is undated, so it is unable to be determined if resident #8's support plan was completed within 72 hours of admission or within 72 hours prior to admission.

Resident #9 was admitted to the SDCU on [redacted]/22; however, resident #9's initial support plan was not completed until [redacted]/23.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Accept ([redacted] - 06/08/2023)***

• On 5/26/2023 Action was taken by ED o Designee to update resident #8's support plan to properly reflect admission window.
• On 05/11/2023 an audit was completed of all resident support plans by ED or designee to determine support plan accuracy. (Exhibit-18.A)
• On 05/11/2023 an education was provided by ED to Administration and HWD on Individualized service plan policy (Exhibit-18.B)
• Documentation of education shall be kept.
• on 05/11/2023 an Education was provided by ED to Memory Care Director and Memory Care Coordinator on regulation 2600.234.a (Exhibit-20.A)
• On 05/11/2023 an education was provided by ED or designee to all resident admissions staff on community move in check list (see attached) and responsibilities. (Please see Exhibit 7.D)

234a - Admission Support Plan (continued)

• On 05/15/2023 A support plan audit to be completed By ED or designee for 4 residents in SDCU weekly for 2 weeks, followed by 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Ongoing measure to be determined at monthly QA meeting held first Thursday of each month. (Exhibit-20.B)

• On 6/1/2023 documentation of quality management revies shall be kept

Licensee's Proposed Overall Completion Date: *07/28/2023*

Not Implemented ([redacted] - 09/22/2023)

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

Facility Information

Name: *THE SHERIDAN AT BETHEL PARK* **License #:** *44948* **License Expiration:** *10/14/2023*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA 15234*

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

Administrator

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

Legal Entity

Name: *KJ BETHEL PARK LLC*

Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA, 15234*

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *12/13/2018* **Issued By:** *Municipality of Bethel Park*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *165* **Waking Staff:** *124*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *06/29/2023*

Inspection Dates and Department Representative

06/27/2023 - On-Site: [redacted]
06/28/2023 - On-Site:
06/29/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* **Residents Served:** *111*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *SDCU* **Capacity:** *40* **Residents Served:** *30*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *111*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *54*
Have Physical Disability: *0*

Inspections / Reviews

06/27/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/09/2023*

08/18/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/20/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/24/2023*

08/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/20/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/20/2023*

09/22/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/20/2023*

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

3c - Post Current License

1. Requirements

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

Description of Violation

On 6/28/23, the home's most recent license inspection summaries, dated 8/30/22, et. al. and 8/1/22, et. al. were not posted in a public and conspicuous place in the home.

REPEAT VIOLATION 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• Immediate action was taken by ED to place both Inspection Summary's sighted in violation in plain view of guests.
• Table was placed in Foyer by ED on 6/30/2023 in open view with Inspection summary binder designated and placed on top for residents and quests. (Please see photo Exhibit 1.A)
• On 8/8/2023 an education on regulation 2600.3.c and its requirements in the community given by Regional Director of Operations to all administrative staff. Record of Education to be kept. (Exhibit 1.B)
• An audit beginning 8/1/2023 to be completed by ED or Designee of foyer for binder placement daily for 1 week followed but weekly for 4 weeks. Record of Audit to be kept. (Exhibit 1.C) (DIRECTED: Beginning on 9/5/23: The administrator shall inspect the home monthly to ensure all items specified in 2600.3c are posted in a public and conspicuous place in the home. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/07/2023*

Not Implemented [redacted] - 09/22/2023)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 6/27/23 at approximately 10:00 am, numerous resident records, to include resident #15's record, were unlocked, unattended and accessible in the 2nd floor care team room.

REPEAT VIOLATION 8/1/2022, et. al.

Plan of Correction ***Accept [redacted] 08/18/2023)***

• On 7/31/2023 Immediate action was taken by HWD to secure resident records in floor 2 care team room. Doorstop was removed from premises by Maintenance Director on 6/27/2023.

17 - Record Confidentiality (continued)

• On 6/30/2023 an education was given by ED to Care staff in regards to regulation 2600.17 and its requirements to secure resident information properly. Record of education to be kept (Exhibit 2.A)

• On 7/31/2023 an Audit of all Care team rooms completed by HWD to ensure all resident records were stored properly and securely and that all doors for each room were properly locked and free of any potential obstructions. (Exhibit 2.B)

• Beginning 7/31/2023 An audit of care team room doors to be completed daily by Supervising med tech or designee, Ounce daily for 2 weeks, followed by 3 times weekly for 2 weeks, followed by once weekly for 2 weeks. Record of audit to be kept. (Exhibit 2.C)

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented [redacted] - 09/22/2023)

20b3 - Written Receipts

3. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

The home manages the finances for resident #6; however, the home did not obtain a written receipt from resident #6 for the following cash disbursements:

- *A $23 cash withdrawal on 6/13/23*
- *A $23 cash withdrawal on 5/25/23*
- *A $23 cash withdrawal on 5/9/23*
- *A $23 cash withdrawal on 4/25/23*

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 7/31/2023 Immediate action was taken by ED to notify the resident and resident family on the violation of regulation 2600.20.B. Meeting to sign for cited cash withdrawals with designated person scheduled for 9/7/2023 (DIRECTED: By 9/5/23: The administrator shall ensure resident #6 signs for the cash withdrawals issued to resident #6 on 4/25/23, 5/9/23, 5/25/23 and 6/13/23. Documentation of the signatures shall be kept. [redacted] 8/30/23).

• On 8/01/2023 an Audit of all residents requiring financial management of funds was performed by ED or Designee. Record of audit to be kept (Exhibit 3.A)

• On 8/01/2023 an education was provided by ED to administrative and concierge staff responsible for assistance with financial management of resident funds in coordination with regulation 2600.20.B. Record of education to be kept. (Exhibit 3.B)

• Beginning 8/2/2023 an audit on resident funds and required signatures by ED or designee to occur twice weekly for 2 weeks followed by once weekly for 2 weeks followed by once bi-weekly for 2 weeks. Record of audit to be kept (Exhibit 3.C)

20b3 - Written Receipts (continued)

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

20b8 - Quarterly Account

4. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home provides financial management for numerous residents, to include resident #3; however, the home has not provided resident #3 or resident #3's designated person with a quarterly account of the resident's financial transactions.

Plan of Correction ***Accept [redacted] - 08/18/2023)***

• on 8/01/2023 immediate action was taken by ED or designee to provide resident #3 and their designated person with a financial statement and inform them of the communities requirement to provide quarterly statements moving forward.
• On 8/01/2023 an audit by ED or designee completed of all residents who have finances managed by community for previous quarterly statements. Record of education to be kept. (Exhibit 4.A)
• On 8/05/2023 an Education was provide by ED to all financially responsible staff members and the requirement for quarterly statements as outlined in regulation 2600.20.b. record of education to be kept. (Exhibit 4.B)
• Beginning on 8/10/2023 an Audit by ED or designee for required quarterly statements of 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks followed by 1 resident Bi-weekly for 2 weeks. Record of documentation to be kept. (Exhibit 4.C)
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented [redacted] - 09/22/2023)

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 6/10/23, the home served 109 residents, including 54 residents with mobility needs. Of the 54 residents with mobility needs, 12 of the residents required the physical assistance of 2 staff persons to transfer in/out of bed/chair.

60a - Staff/Support Plan (continued)

The most recent documentation from the fire safety expert, dated 8/30/22, indicates the maximum evacuation time to the home's fire-safe areas is 7 minutes. On 6/10/23 from approximately 10:00 pm through 6:30 am, only 3 staff persons were present in the home, which is not adequate to safely evacuate all residents in the event of an emergency.

Plan of Correction ***Directed (- 08/30/2023)***

• On 7/31/2023 Immediate action was taken by ED to evaluate and adjust staffing levels with scheduling manager by staffing 6 aides on the shift. 2 more than previously staffed.
• On 7/31/2023 overnight shift was adjusted by ED and scheduling manager to accommodate adequate staffing levels for the 10:00 pm through 6:30 am shift.
• On 7/31/2023 ED and staffing manager audited scheduled days from 6/27 through 7/31 to verify proper staffing levels were being met. Record of documentation to be kept. (Exhibit 5.A)
• On 7/31/2023 and education was provided to scheduling manager, Personal Care Director, Memory Care Director on proper staffing levels to meet needs of the resident in coordination with regulation 2600.60.A Record of Education to be kept. (Exhibit 5.B). On 9/12/2023, overnight fire drill to be completed by MD ensuring adequate response time. Record of drill to be kept. (DIRECTED: The sleeping hours fire drill scheduled for 9/12/23 shall be conducted with the minimum number of staff persons scheduled. Documentation of the fire drill shall be kept in accordance with 2600.132c. 8/30/23).
• On 8/05/2023 an audit of the schedule's staffing levels by ED or designee to occur 7 times weekly for 2 weeks -(UNACCEPTABLE PORTION OF PLAN OF CORRECTION. 8/30/23) Record of documentation to be kept. (Exhibit 5.C) (DIRECTED: Beginning on 9/1/23: The administrator/scheduling manager shall review the home's direct care staffing schedule daily to ensure adequate staffing is scheduled in the home accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/12/2023*

Not Implemented - 09/22/2023)

65a - FS Orientation 1st Day

6. Requirements

2600.
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:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

65a - FS Orientation 1st Day *(continued)*

Description of Violation

Staff person B, hired on [redacted]23, did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction ***Accept [redacted] - 08/30/2023)***

• On 8/05/2023 a community on boarding class which includes all requirements in coordination with regulation 2600.65.a was scheduled for Staff member on 8/17/2023 by Business office manager. (Next time available) record of education to be kept.

• On 8/02/2023 all employee files audited by ED or designee to ensure proper onboarding steps were taken during the hiring and training process. (Exhibit 6.A)

• On 08/05/2023 an education was provided by ED for employee processing staff on proper onboarding requirements in coordination with regulation 2600.65.A. Record of education to be kept. (Exhibit 6.B)

• Beginning 8/05/2023 an Audit of 4 employee files for onboarding requirements by ED or designee to be completed 2 times weekly for 2 weeks followed by 1 time weekly for 2 weeks followed by 1 time bi-weekly for 2 weeks. Record of documentation to be kept. (Exhibit 6.C)

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Community has been implementing new hire check list for all new hire employees since new ED hired on [redacted]/2023. (exhibit 6.D)

On 9/12/2023 an Education on Company new hire check list to be provided to all staff responsible in the hiring process by ED.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented [redacted] - 09/22/2023)

65b - Rights/Abuse 40 Hours

7. Requirements

2600.

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

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.

Description of Violation

Staff person B, hired on [redacted]23, did not receive orientation on any of the topics specified in 2600.65b.

Plan of Correction ***Accept [redacted] 08/30/2023)***

• On 8/05/2023 a community on boarding class which includes all requirements in coordination with regulation 2600.65.b was scheduled for Staff member on 8/17/2023 by Business office manager. (Next time available) record of education to be kept.

• On 8/02/2023 all employee files audited by ED or designee to ensure proper onboarding steps were taken during the hiring and training process. (Exhibit 6.A)

• On 08/05/2023 an education was provided by ED for employee processing staff on proper onboarding requirements in coordination with regulation 2600.65.A. Record of education to be kept. (Exhibit 6.B)

65b - Rights/Abuse 40 Hours (continued)

• Beginning 8/05/2023 an Audit of 4 employee files for onboarding requirements by ED or designee to be completed 2 times weekly for 2 weeks followed by 1 time weekly for 2 weeks followed by 1 time bi-weekly for 2 weeks. Record of documentation to be kept. (Exhibit 6.C)

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Community has been implementing new hire check list for all new hire employees since new ED hired on [redacted]/2023. (exhibit 6.D)

On 9/12/2023 an Education on Company new hire check list to be provided to all staff responsible in the hiring process by ED.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented [redacted] - 09/22/2023)

65e - 12 Hours Annual Training

8. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A, hired on [redacted]/21, received only 2 hours of annual training during the 2022 training year.

Direct care staff person C, hired on [redacted]/21, received only 2 hours of annual training during the 2022 training year.

Plan of Correction ***Directed ([redacted] - 08/30/2023)***

• On 8/01/2023 Immediate action was taken to assess all active employees in the community by ED, HWD, PCD and MCD to determine what employees required yearly staff trainings.

Staff person A no longer works for the Sheridan.

On 9/12/2023 staff person C is scheduled to complete previous training requirements through Relias in coordination with regulation 2600.65.e. (DIRECTED: Documentation of staff person C's training shall be kept in accordance with 2600.65i. [redacted] 8/30/23).

• As of 1/01/2023, All mandatory employee trainings made accessible via Relias online program.

• On 8/01/2023 an audit was conducted by ED or designee of all current staffs 12-month training requirements. Record of documentation to be kept. (Exhibit 8.A)

• On 8/05/2023 an education provided by ED to all Direct care staff on meeting 12-month training requirements outlined in regulation 2600.65 was given. Record of education to be kept (Exhibit 8.B)

• On 8/10/2023 An Audit of employee Trainings requirements to be completed by ED or designee for 4 employees twice weekly for 2 weeks followed by once weekly for 1 week followed by once biweekly for 2 weeks. Record of documentation to be kept. (Exhibit 8.C)

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept

During onboarding new staff are given a Relias login. In Relias monthly trainings are designated for each staff member. Email and text alerts are communicated to staff. Any individual past due of mandatory DHS required

65e - 12 Hours Annual Training (continued)

trainings is removed from the schedule until completion.
ED is able to monitor Relias trainings of all employees monthly. Utilizing Quality assurance monthly meeting to discuss with departments. (DIRECTED: Beginning on 9/7/23: The administrator shall review direct care staff training records monthly to ensure all direct care staff persons receive at least 12 hours of annual training during each training year. [redacted] 8/30/23).
Employees are required to find time either at work from home to complete required trainings. If required trainings are completed from home. Staff is compensated their hourly rate for doing so. ED is capable of monitoring date and time of training.

Directed Completion Date: *09/20/2023*

Not Implemented ([redacted] - 09/22/2023)

65f - Training Topics

9. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

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.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.

Description of Violation

Direct care staff person A, hired on [redacted]/21, did not receive training on any of the training topics specified under 2600.65f during the 2022 training year.

Direct care staff person C, hired on [redacted]/21, did not receive training on any of the training topics specified under 2600.65f during the 2022 training year.

Plan of Correction ***Directed ([redacted] - 08/30/2023)***

• On 8/01/2023 Immediate action was taken to assess all active employees in the community by ED, HWD, PCD and MCD to determine what employees required yearly staff trainings.
• As of 1/01/2023, All mandatory employee trainings made accessible via Relias online program.
Staff person A no longer works for the Sheridan.
on 9/12/2023 staff person C is scheduled to complete all previously required trainings. Monitored and verified by ED or Designee. Record of education to be kept.
• On 8/01/2023 an audit was conducted by ED or designee of all current staffs 12-month training requirements. Record of documentation to be kept. (Exhibit 8.A)
• On 8/05/2023 an education provided by ED to all Direct care staff on meeting 12-month training requirements outlined in regulation 2600.65 was given. Record of education to be kept (Exhibit 8.B)
• On 8/10/2023 An Audit of employee Trainings requirements to be completed by ED or designee for 4 employees twice weekly for 2 weeks followed by once weekly for 1 week followed by once biweekly for 2 weeks. Record of documentation to be kept. (Exhibit 8.C)
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning

65f - Training Topics (continued)

9/7/2023. Records of meeting to be kept.
During onboarding new staff are given a Relias login. In Relias monthly trainings are designated for each staff member. Email and text alerts are communicated to staff. Any individual past due of mandatory DHS required trainings is removed from the schedule until completion.
ED is able to monitor Relias trainings of all employees monthly. Utilizing Quality assurance monthly meeting to discuss with departments. (DIRECTED: Beginning on 9/7/23: The administrator shall review direct care staff training records monthly to ensure all direct care staff persons receive training on all topics specified in 2600.65f during each training year. [redacted] 8/30/23).
Employees are required to find time either at work from home to complete required trainings. If required trainings are completed from home. Staff is compensated their hourly rate for doing so. ED is capable of monitoring date and time of training.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

65g - Annual Training Content

10. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Direct care staff person A, hired on [redacted] /21, did not receive training on any of the training topics specified under 2600.65g during the 2022 training year.

Direct care staff person C, hired on [redacted] /21, did not receive training on any of the training topics specified under 2600.65g during the 2022 training year.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 8/01/2023 Immediate action was taken to assess all active employees in the community by ED, HWD, PCD and MCD to determine what employees required yearly staff trainings.
Staff person A no longer works at the Sheridan.
on 9/12/2023 staff person C is scheduled to complete all previously required trainings via Relias. (DIRECTED: Documentation of staff person C's trainings shall be kept in accordance with 2600.65i. [redacted] 8/30/23).
• As of 1/01/2023, All mandatory employee trainings made accessible via Relias online program.
• On 8/01/2023 an audit was conducted by ED or designee of all current staffs 12-month training requirements.

65g - Annual Training Content (continued)

Record of documentation to be kept. (Exhibit 8.A)
• On 8/05/2023 an education provided by ED to all Direct care staff on meeting 12-month training requirements outlined in regulation 2600.65 was given. Record of education to be kept (Exhibit 8.B)
• On 8/10/2023 An Audit of employee Trainings requirements to be completed by ED or designee for 4 employees twice weekly for 2 weeks followed by once weekly for 1 week followed by once biweekly for 2 weeks. Record of documentation to be kept. (Exhibit 8.C)
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

During onboarding new staff are given a Relias login. In Relias monthly trainings are designated for each staff member. Email and text alerts are communicated to staff. Any individual past due of mandatory DHS required trainings is removed from the schedule until completion.
ED is able to monitor Relias trainings of all employees monthly. Utilizing Quality assurance monthly meeting to discuss with departments. (DIRECTED: Beginning on 9/7/23: The administrator shall review all staff training records monthly to ensure all staff persons receive training on all topics specified in 2600.65g during each training year. [redacted] 8/30/23).
Employees are required to find time either at work from home to complete required trainings. If required trainings are completed from home. Staff is compensated their hourly rate for doing so. ED is capable of monitoring date and time of training.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

85a - Sanitary Conditions

11. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 6/29/23, there was an unlabeled shower loofah in the shared shower of residents #7 and #12.

On 6/29/23, there were multiple unlabeled toiletry and personal care items in the shared bathroom of residents #7 and #12, to include combs, toothbrushes and razors.

Plan of Correction ***Accept [redacted] - 08/30/2023)***

• On 7/31/2023 Immediate action was taken by HWD to notify residents #7 and #12 of the unlabeled items in shared space amongst the room. It was requested by HWD that Family please label items appropriately in shared space.
on 7/31/2023 Immediate action was taken by HWD to remove unlabeled items from shared room until family could identify.
• On 7/31/2023 and Audit was completed by HWD, MCD, and ED of all shared rooms and their resident's personal

85a - Sanitary Conditions (continued)

affects in shared spaces for proper labeling. Record of documentation to be kept (Exhibit 11.A)
• On 8/05/2023 an Education was provided to all admission, care, ancillary, and administrative staff on proper labeling of personal items in shared spaces in coordination with regulation 2600.85.a. Record of education to be Kept (Exhibit 11.B)
• On 8/10/2023 an Audit by ED or designee to identify unlabeled items in shared spaces for 2 shared rooms to occur twice weekly for 2 weeks followed by once weekly for 2 weeks followed by once bi-weekly for 2 weeks. Record of documentation to be kept. (Exhibit 11.C)
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented [redacted] - 09/22/2023)

102f - Towel/Washcloth/Soap

13. Requirements

2600.
102.f. An individual towel, washcloth and soap shall be provided for each resident.

Description of Violation

On 6/29/23, there was an unlabeled towel in the shared bathroom of residents #7 and #12.

Plan of Correction ***Accept [redacted] - 08/30/2023)***

On 7/31/2023 Immediate action was taken by HWD to remove towels from shared room until family could properly identify.
• On 7/31/2023 Immediate action was taken by HWD to notify residents #7 and #12 of the unlabeled items in shared space amongst the room. It was requested by HWD that Family please label items appropriately in shared space.
(Towel holders are labeled in the community but residents do not always utilize appropriately)
• On 7/31/2023 and Audit was completed by HWD, MCD, and ED of all shared rooms and their resident's personal affects in shared spaces for proper labeling. Record of documentation to be kept (Exhibit 11.A)
• On 8/05/2023 an Education was provided to all admission, care, ancillary, and administrative staff on proper labeling of personal items in shared spaces in coordination with regulation 2600.102.f. Record of education to be Kept (Exhibit 13.A)
• On 8/10/2023 an Audit by ED or designee to identify unlabeled items in shared spaces for 2 shared rooms to occur twice weekly for 2 weeks followed by once weekly for 2 weeks followed by once bi-weekly for 2 weeks. Record of documentation to be kept. (Exhibit 11.C)
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented [redacted] - 09/22/2023)

103e - Left Overs

14. Requirements

103e - Left Overs *(continued)*

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

Description of Violation

On 6/27/23, there was an unlabeled and undated container of white chocolate cookies present on the 1st floor secured dementia care unit (SDCU) kitchenette counter.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed ([redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by Memory Care Director to remove undated and unlabeled items brought in by a family member from SDCU.
• On 7/31/2023 Immediate action was taken by MCD to check both SDCU floor's common areas for unlabeled and undated food items.
• On 8/05/2023 an Education was provided by ED to SDCU Staff and director on proper storage and labeling of food related items in the SDCU in coordination with regulation 2600.103. Record of education to be kept (Exhibit 14.A)
• On 8/05/2023 signage was posted by MCD director on proper storage and labeling of food items for family members entering the unit for visitation purposes. (See Photo)
• Beginning 8/05/2023, MCD or designee to complete daily walkthrough of community not limited to SDCU to ensure proper food storage requirements are being met. MCD or designee to complete walkthrough twice daily for 2 weeks followed by once daily for 2 weeks followed by 3 times weekly for 2 weeks. Record of documentation to be kept (Exhibit 14.b) (DIRECTED: Beginning on 9/20/23: The MCD/designee shall conduct a walkthrough of all food storage areas weekly to ensure all leftover food items are labeled and dated. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

DIRECTED: By 9/15/23: All staff persons shall be educated that leftover food items must be labeled and dated. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 8/30/23

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

103g - Storing Food

15. Requirements

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

Description of Violation

On 6/27/23, the following unsealed items were present in the 1st floor SDCU kitchenette:

- *A loaf of white bread*
- *A bag of Ruffles potato chips*
- *A bag of Cheerios*
- *A bag of Corn Chex*

103g - Storing Food (continued)

Plan of Correction ***Directed (- 08/30/2023)***

• On 7/31/2023 immediate action was taken by MCD to remove listed food items from unit.
• On 7/31/2023 Immediate action was taken by MCD to check both SDCU floor's common areas for unlabeled and undated food items.
• On 8/05/2023 an Education was provided by ED to SDCU Staff and director on proper storage and labeling of food related items in the SDCU in coordination with regulation 2600.103. Record of education to be kept (Exhibit 14.A)
• On 8/05/2023 signage was posted by MCD director on proper storage and labeling of food items for family members entering the unit for visitation purposes. (See Photo)
• Beginning 8/05/2023, MCD or designee to complete daily walkthrough of community not limited to SDCU to ensure proper food storage requirements are being met. MCD or designee to complete walkthrough twice daily for 2 weeks followed by once daily for 2 weeks followed by 3 times weekly for 2 weeks. Record of documentation to be kept (Exhibit 14.b) (DIRECTED: Beginning on 9/20/23: The MCD/designee shall conduct a walkthrough of all food storage areas weekly to ensure all food items are stored in closed or sealed containers. 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

DIRECTED: By 9/15/23: All staff persons shall be educated that all food items must be stored in closed or sealed containers. Documentation of the education shall be kept in accordance with 2600.65i. 8/30/23

Directed Completion Date: *09/20/2023*

Not Implemented - 09/22/2023)

132h - Designated Meeting Place

16. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill conducted on 6/20/23 at 4:11 am, there were 112 residents in the home; however, only 4 residents were evacuated to a fire-safe area.

During the fire drill conducted on 2/21/23 at 11:45 pm, there were 119 residents in the home; however, only 13 residents were evacuated to a fire-safe area.

Plan of Correction ***Directed - 08/30/2023)***

• On 8/2/2023 Maintenance director preformed community fire drill. All residents evacuated to fire safe areas of the community designated by Fire Safety Expert.
• On 8/2/2023 Education was provided to Staff following fire Drill by ED and MD on fire safety in the community in coordination with regulation 2600.132.H. Record of education to be kept. (Exhibit 16.A)

132h - Designated Meeting Place (continued)

• On 7/31/2023 overnight shift was adjusted by ED and scheduling manager to accommodate adequate staffing levels for the 10:00 pm through 6:30 am shift to provide additional support.
• On 7/31/2023 ED and staffing manager audited scheduled days from 6/27 through 7/31 to verify proper staffing levels are being met. Record of documentation to be kept. (Exhibit 5.A)
• On 08/29/2023 Education was provided to direct care staff by Fire safety expert on fire safety requirements within the community. Record of education to be kept. (Exhibit 16.B)
• On 8/05/2023 an audit of the schedule's staffing levels by ED or designee to occur twice weekly for 2 weeks followed by once weekly for 2 weeks followed by once bi-weekly for one week. Record of documentation to be kept. (Exhibit 5.C)
• On going measures to be discussed including fire drill record monitoring monthly by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

DIRECTED: Beginning on 9/1/23: The administrator shall review the home's fire drill records monthly to ensure all residents evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill. [redacted] 8/30/23

Directed Completion Date: *09/07/2023*

Not Implemented [redacted] - 09/22/2023)

132i - Testing Fire Alarm

17. Requirements

2600.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

According to the home's fire drill records, the fire alarm was not activated during the fire drill that was conducted on 6/20/23 at 4:11 am.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 8/2/2023 Maintenance director preformed community fire drill in which fire alarms were activated.
• On 08/29/2023 Education was provided to MD, ED, and direct care staff by Fire safety expert on fire safety requirements within the community. Record of education to be kept. (Exhibit 16.B)
• An Audit of fire drills to begin 8/29/2023 by ED or designee to ensure alarm activation during preformed drill. [redacted] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] 8/30/23). (DIRECTED: Beginning on 9/1/23: The administrator shall review the home's fire drill records monthly to ensure a fire alarm or smoke detector is set off during each fire drill. [redacted] 8/30/23). Record of documentation to be kept. (Exhibit 17.A)
• On going measures to be discussed including fire drill record monitoring monthly by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/21/2023*

Not Implemented [redacted] 09/22/2023)

141a - Medical Evaluation

18. 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 #6's medical evaluation, dated [redacted]/23, does not include resident #6's weight. This section of the form is blank.

REPEAT VIOLATION 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 8/05/2023 Action was taken By HWD or designee coordinate with resident physician to obtain and include missing information listed above.
on 8/05/2023
Missing information was updated for initial DME on 08/05/2023 in coordination with physicians records.
On 5/11/2023 ED created a new admission check list for use with incoming residents. (DIRECTED: Copies of the completed new admission checklists shall be kept in each newly admitted resident's record. [redacted] 8/30/23).
on 8/31/2023 Ed provided an education on new admission check list and its relation to regulation 2600.141.a and required medical evaluation info. Record of documentation to be kept.
• On 8/06/2023 an audit of all initial DME's was preformed by PCD or designee to determine compliance across all resident files. Record of documentation to be kept (Exhibit 18.A)
• On 8/05/2023 an Education was provided by ED to PCD, HWD, and MCD on proper DME information required on DME in coordination with Regulation 2600.141. Record of education to be kept. (Exhibit 18.B)
• Considering repeat violation status beginning 8/05/2023, resident annual DME to be completed by community RN and sent to physician for review. New residents moving into community to have RN overview of documentation before arrival into community to ensure compliance.
• An audit of resident DMEs to begin 8/05/2023 by ED, HDW, or designee of 6 residents weekly for 2 weeks, followed by 4 residents weekly for 2 weeks, followed by 2 residents weekly for 2 weeks. Record of documentation to be kept. (Exhibit18.C) (DIRECTED: The audits shall be conducted within 24 hours of completion of the medical evaluations. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented ([redacted] - 09/22/2023)

141b1 - Annual Medical Evaluation

19. Requirements

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

Resident #2's most recent medical evaluation was completed on [redacted]/22; however, resident #2's previous medical evaluation was completed on [redacted]/20.

Resident #4's most recent medical evaluation, which was signed by the medical professional who completed the form on [redacted]/22, does not include the date resident #4 was evaluated, or resident #4's weight. These sections of the form are blank.

Resident #5's most recent medical evaluation, which was signed by the medical professional who completed the form on [redacted]/22, does not include the date resident #5 was evaluated, or resident #5's weight, height, pulse rate, blood pressure, and temperature. These sections of the form are blank.

Resident #8's most recent medical evaluation, signed by the medical professional who completed the form on [redacted]/22, does not include the date resident #8 was evaluated, resident #8's weight or a current list of medications. These sections of the form are blank.

Resident #10's most recent medical evaluation, which was signed by the medical professional who completed the form on [redacted]/22, does not include the date resident #10 was evaluated, the date the form was completed or a list of resident #10's current medications. These sections of the form are blank.

REPEAT VIOLATION: 8/30/2022, et. al.; 8/1/2022, et. al.; 12/28/2022

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 8/05/2023 Action was taken By HWD or designee to coordinate with resident physicians to obtain and include missing information on medical evaluations for all residents listed. Completed 8/05/2023 (DIRECTED: Copies of the updated medical evaluations shall be kept in each resident's record. [redacted] 8/30/23).
Previous administration responsible for DME at admission lack of understanding for incoming residents.
• On 8/06/2023 an audit of all DME's was performed by PCD or designee to determine compliance across all resident files. Record of documentation to be kept (Exhibit 18.A)
On 8/05/2023 an Education was provided by ED to PCD, HWD, and MCD on proper DME information required on DME in coordination with Regulation 2600.141. and community process for tracking Resident DME's in company computer system, YARDI. Record of education to be kept. (Exhibit 18.B)
beginning 8/29/2023 HWD to review Company DME tracker Monthly.
• Considering repeat violation status beginning 8/05/2023, resident annual DME to be completed by community RN and sent to physician for review. New residents moving into community to have RN overview of documentation before arrival into community to ensure compliance.
• An audit of resident DMEs to begin 8/05/2023 by ED, HDW, or designee of 6 residents weekly for 2 weeks, followed by 4 residents weekly for 2 weeks, followed by 2 residents weekly for 2 weeks. Record of documentation to be kept. (Exhibit18.C) (DIRECTED: The audits shall be conducted within 24 hours of completion of the medical evaluations. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting including upcoming or overdue DME changes in community. beginning 9/7/2023. Records of meeting to be kept.

141b1 - Annual Medical Evaluation (continued)

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

144c1 - Smoking Area Guidelines

20. Requirements

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

Description of Violation

On 6/28/23 at approximately 9:55 am, resident #9 was smoking at the front entrance of the home, which is not the designated smoking area of the home.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 7/31/2023 at approximately 9:55am Immediate action was taken by ED to direct resident #9 away from front entrance to the designated smoking area several feet away after it was observed while inspecting community transport with Surveyor of the violation in policy. At this time resident was informed of smoking area and reminded of agreed upon smoking policy per community residential agreement. See attached. (Exhibit 20.A)
• On 8/05/2023 an education by ED was provided to concierge staff about Community Smoking policy and designated area in coordination with regulation 2600.144.c. Concierge monitor front entry wat and redirect individuals not incompliance with community smoking policy. Record of education to be kept. (Exhibit 20.B)
• On 8/05/2023 resident charts were audited for signature on Agreed upon smoking policy by ABOM to ensure resident compliance.
• Beginning 7/31/2023 during community lease signing, ED to explain and obtain signature by resident for community smoking policy.
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.
Beginning 8/30/2023 front desk staff to patrol parameter of the community twice daily.
on 8/30/2023 an Education to be provided by ED or Designee to front desk staff on requirements for designated smoking are patrol daily.

DIRECTED: By 9/15/23: The administrator shall re-educate all staff persons and residents on the location of the home's designated smoking areas and that smoking is only permitted in the designated areas. Documentation of the education shall be kept.[redacted] 8/30/23

Directed Completion Date: *09/15/2023*

Not Implemented [redacted] - 09/22/2023)

171b4 - Staff Training

21. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Staff person D transports residents using home's van; however, staff person D has not successfully completed and passed the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept [redacted] - 08/18/2023)***

• 7/31/2023 immediate action was taken by ED to provide Staff person D access to department approved direct care training course.
• On 7/31/2023 Staff person D resigned their position from the community.
• On 8/05/2023 an audit was completed by ED of staff providing transport for residents in the community for compliance with regulation 2600.171.b. Record of documentation to be kept. (Exhibit 21.A)
• On 8/05/2023 an education by ED was provided to hiring staff and scheduling manager on requirements for transportation of residents in coordination with regulation 2600.171.A. Record of education to be kept. (Exhibit 21.B)
• On 8/05/2023 an audit completed by ED or designee of all staff providing transport to occur once weekly for 3 weeks followed by once bi-weekly for 3 weeks. (only three staff members provide transport.) Record of documentation to be Kept.
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented [redacted] - 09/22/2023)

183d - Prescription Current

22. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 5/28/23, resident #4's Acetaminophen PM was discontinued; however, was still present in the home on 6/29/23.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by HWD to remove discontinued medication present in the home for resident #4.
• On 7/31/2023 an Audit of all resident Mars and their medications completed by HWD or designee to identify and resolve medication issues and remove any DC'd ,meds as they relate to regulation 2600.183.d. Record of documentation to be kept. (Exhibit 22.A)
• On 8/05/2023 an education was provided to HWD and Medtech staff on proper disposal of discontinued medication in the community and their responsibility once a medication is discontinued. Record of education to be

183d - Prescription Current (continued)

kept. (Exhibit 22.B)

• Beginning 8/10/2023 HWD or designee to complete an audit of 5 resident orders/Medication records once weekly for 2 weeks follow by 5 resident weekly for 2 weeks followed by 2 residents weekly for 2 weeks. Record of documentation to be kept. (Exhibit 22.C) (DIRECTED: Immediately following the completion of the weekly audits, medication audits shall be completed for at least 5 residents per month. [redacted] 8/30/23).

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

183e - Storing Medications

23. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #3 is prescribed Oxycodone HCl 5 mg-Take 1 tablet by mouth every 6 hours as needed. On 6/29/23, pill #27 was punctured in the back of the medication blister pack and was not sealed.

Plan of Correction ***Accept [redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by HWD to coordinate with pharmacy to replace resident #3's damaged, prescribed medication. Medication was sent from pharmacy same day stat.
on 7/31/2023 immediate action was taken by HWD to dispose of damaged prescribed medication.

• On 7/31/2023 an audit of medication carts was performed by HWD or designee to check for proper storage of medications in community. Record of Documentation to be kept. (Exhibit 23.A)

• On 8/05/2023 an Education was Provide by HWD to Medtech staff on identification of damaged packaging and the correct response in coordination with regulation 2600.18.e. Record of education to be kept. (Exhibit

• Beginning 8/10/2023 an audit of all medication carts by HWD or Designee to be completed twice weekly for 2 weeks followed by once weekly for 2 weeks followed by once bi-weekly for 2 weeks.

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented [redacted] - 09/22/2023)

185a - Implement Storage Procedures

24. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 6/16/23 at approximately 4:00 pm, resident #3's blood sugar was 357; however, was documented on resident #3's June 2023 medication administration record (MAR) as 375.

On 6/29/23, resident #6's glucometer was not labeled with resident #6's name.

Resident #7 is prescribed Morphine Sulfate 100mg/5ml-Take 0.25 ml sublingually ever 1 hour as needed; however, this medication was not available in the home for administration on 6/29/23.

Plan of Correction ***Directed (- 08/30/2023)***

• On 7/31/2023 Immediate action was taken by HWD to assess residents #3 and #7 for any adverse side effects. Vitals were taken.
• On 7/31/2023 Immediate action was taken by HWD to properly label resident #6 glucometer.
• On 7/31/2023 Immediate action was taken by HWD to educate MedTech who improperly documented blood sugar in mar.
• On 7/31/2023 Immediate action was taken by HWD to coordinate with resident #7's preferred pharmacy to arrange for medication delivery. medication delivered to community from pharmacy same day stat.
on 8/01/2023 HWD or designee completed audit of all Glucometers and proper resident labeling.
• On 8/05/2023 an education was provided by ED to MedTech staff on company Medication policy which includes, proper documentation, pharmacy refill process and proper storage of medication. Record of education to be kept.
• Beginning 8/10/2023 an audit of all medication carts, Mar's and Glucometer readings by HWD or Designee to be completed twice weekly for 2 weeks followed by once weekly for 2 weeks followed by once bi-weekly for 2 weeks. (DIRECTED: Immediately following the completion of the weekly audits, medication audits, MAR reviews and glucometer reviews shall be completed for at least 5 residents per month to ensure all prescribed medications are available, accurate blood sugar documentation is obtained and that resident glucometers are labeled with resident names. 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting including proper labeling of Glucometers beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented - 09/22/2023)

187a - Medication Record

25. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.

187a - Medication Record *(continued)*

7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #3 is prescribed Aspart Flexpen insulin-100u/ml-Inject subcutaneously 3 times daily in accordance with the following sliding scale: 0-200=0 units; 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-450=10 units; 451-500=12 units; >500=call MD. However, resident #3's June 2023 MAR indicates resident #3's sliding scale as: 141-180=1 unit; 181-220=2 units.

Resident #3 is prescribed Aspart Flexpen insulin-100u/ml-Inject subcutaneously 3 times daily in accordance with the following sliding scale: 0-200=0 units; 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-450=10 units; 451-500=12 units; >500=call MD. However, resident #3's June 2023 MAR does not include the number of units of insulin that were administered to resident #3 on numerous dates and times, to include at 12:00 pm on 6/6/23 and 6/17/23.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 7/31/2023 Immediate action was taken by HWD to assess vitals for resident #3 on 8/29/2023 action was taken by HWD to reach out to resident pharmacy and physicians to make changes to accurately reflect current medication orders as prescribed by physician.
• On 8/05/2023 an audit was completed by HWD or Designee of all residents requiring sliding scale insulin. Record of documentation to be kept (Exhibit 25.A)
• On 08/10/2023 an education was provided by ED to HWD, PCD, MCD, Medical Records clerk and all MedTech staff on proper record keeping and MD orders in coordination with regulation 2600.187 Record of documentation to be kept. (Exhibit 25.B)
• Beginning on 8/10/2023 an audit of proper instructions and dosage by HWD or Designee for 3 residents requiring sliding scale insulin weekly for 2 weeks followed by 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Record of documentation to be kept. (Exhibit 25.C) (DIRECTED: Immediately following the completion of the weekly audits, MAR audits shall be completed for at least 5 residents per month to ensure accurate and complete MAR's are present. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

187b - Date/Time of Medication Admin.

26. Requirements

2600.

187b - Date/Time of Medication Admin. *(continued)*

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Numerous medications for resident #2 were not documented as administered on resident #2's June 2023 MAR on 6/23/23 and 6/24/23, to include the following:

- *Duloxetine HCL 60mg-Take 1 capsule by mouth once a day at 9:00 pm*
- *Levothyroxine 50 mcg-Take 1 tablet by mouth once a day at 9:00 pm*

Resident #3 is prescribed Sucralfate 1gm-Take 1 tablet by mouth 4 times a day; however, this medication was not documented as administered on resident #3's June 2023 MAR at 1:00 pm on 6/6/23 and 6/17/23.

Numerous medications for resident #3 were not documented as administered on resident #3's June 2023 MAR on 6/23/23 and 6/24/23, to include the following:

- *Sucralfate 1gm-Take 1 tablet by mouth times a day*
- *Pantoprazole Sodium 40 mg-Take 1 tablet by mouth twice a day*

Resident #3 is prescribed Levothyroxine Sodium 25 mcg-Take 1 tablet by mouth daily; however, this medication is not documented as administered on resident #3's June 2023 MAR on the following dates: 6/2/23, 6/3/23, 6/14/23, 6/18/23, 6/23/23 and 6/24/23.

Numerous medications for resident #4 were not documented as administered on resident #4's June 2023 MAR on 6/23/23 and 6/24/23, to include the following:

- *Amlodipine Besylate 5mg-Take 1 tablet by mouth once a day*
- *Atorvastatin Calcium 20 mg-Take 1 tablet by mouth once a day*
- *Carvedilol 6.24 mg-Take 1 tablet by mouth twice a day*

Numerous medications for resident #6 were not documented as administered on resident #6's June 2023 MAR on 6/23/23 and 6/24/23, to include the following:

- *Digoxin 0.125-Take 1 tablet by mouth 1 time a day*
- *Furosemide 80 mg-Take 1 tablet by mouth in the morning*
- *Metoprolol Tart 100 mg-Take 1 tablet by mouth twice a day*

Numerous medications for resident #7 were not documented as administered on resident #7's June 2023 MAR on 6/23/23 and 6/24/23, to include the following:

- *Amlodipine Besylate 10mg-Take 1 tablet by mouth once a day*
- *Benazepril HCL 20mg-Take 1 tablet by mouth once a day*
- *Clopidogrel 75 mg-Take 1 tablet by mouth once a day*

Numerous medications for resident #8 were not documented as administered on resident #8's June 2023 MAR on 6/23/23 and 6/24/23, to include the following:

- *Amlodipine Besylate 5mg-Take 1 tablet by mouth once a day*
- *Furosemide 40mg-Take 1 tablet by mouth once a day*
- *Primidone 50mg-Take 1 tablet by mouth 3 times a day*

187b - Date/Time of Medication Admin. (continued)

Resident #9 is prescribed Potassium Chloride 20 MEQ-Take 1 tablet by mouth twice daily; however, this medication was only documented once as being administered on resident #9's June 2023 MAR on 6/20/23 and 6/23/23.

Resident #11 is prescribed Alprazolam 0.5 mg-Take 1 tablet by mouth 3 times a day; however, this medication was only documented twice as being administered on resident #11's June 2023 MAR on 6/25/23 and 6/27/23.

Resident #11 is prescribed Levothyroxine Sodium 50mcg-Take 1 tablet by mouth once a day; however, this medication was not documented as administered on resident #11's June 2023 MAR on 6/16/23, 6/18/23, 6/23/23 and 6/24/23.

Resident #14 is prescribed Olanzapine 2.5 mg-Take 1 tablet by mouth twice a day; however, this medication was only documented once as being administered on resident #14's June 2023 MAR on 6/2/23, 6/8/23 and 6/26/23.

Plan of Correction ***Accept [redacted] - 08/30/2023)***

• On 08/01/2023 Immediate action was taken by HWD to monitor vitals for resident's #2,3,4,5,7,8,9,11,and 14.
• On 08/01/2023 a MAR to cart audit was performed for all residents by HWD or designee to ensure medication was properly given by staff. Record of documentation to be kept (Exhibit 26.a)
• On 08/10/2023 an Education was provided to all MedTech Staff on properly documenting medication in mars for each resident in coordination with regulation 2600.187. Record of education to be kept. (Exhibit 25.B)
• Beginning on 8/10/2023 a Mar to Cart review audit To be performed by HWD or Designee for 5 residents daily for 2 weeks followed by 5 residents weekly for 6 weeks followed by 5 residents monthly. record of documentation to be kept. (Exhibit 26.B)
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.
Root cause of the issue is staff prior lack of awareness when passing medication. Staff would pass meds but move on to the next resident before signing off completely rushing the process.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented ([redacted] - 09/22/2023)

187d - Follow Prescriber's Orders

27. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #3 is prescribed Sucralfate 1gm-Take 1 tablet by mouth 4 times a day; however, this medication was only administered 3 times to resident #3 on 6/16/23.

Resident #3 is prescribed Aspart Flexpen insulin-100u/ml-Inject subcutaneously 3 times daily in accordance with the following sliding scale: 0-200=0 units; 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units; 401-450=10 units; 451-500=12 units; >500=call MD. On numerous dates and times, resident #3 was administered the incorrect amount of insulin, to include the following:

- *6/18/23 at 12:00 pm: Blood sugar was 294 and 4 units of insulin should have been administered; however,*

187d - Follow Prescriber's Orders (continued)

only 2 units of insulin were administered

- *6/17/23 at 4:00 pm: Blood sugar was 316 and 6 units of insulin should have been administered; however, only 2 units of insulin were administered*
- *6/5/23 at 4:00 pm: Blood sugar was 306 and 6 units of insulin should have been administered; however, only 2 units of insulin were administered*
- *6/2/23 at 4:00 pm: Blood sugar was 395 and 8 units of insulin should have been administered; however, only 4 units of insulin were administered*

On 5/16/23, resident #6 was prescribed Acetaminophen 500 mg-Take 2 tablets by mouth every 6 hours; however, the home has been administering the medication to resident #6 every 8 hours.

Resident #6 is prescribed Acetaminophen 500 mg-Take 2 tablets by mouth every 6 hours; however, this medication was only administered 1 time daily to resident #6 on 6/27/23 and 6/28/23.

Resident #9 is prescribed Midodrine HCl 5 mg-Take 1 tablet by mouth 3 times a day; however, this medication was only administered twice to resident #9 on 6/28/23.

Resident #9 is prescribed Potassium Chloride 20 MEQ-Take 1 tablet by mouth twice daily; however, this medication was only administered once to resident #9 on 6/28/23.

Resident #9 is prescribed Atorvastatin Calcium 40mg-Take 1 tablet by mouth once a day; however, this medication was not administered to resident #9 on 6/15/23 and 6/20/23.

Resident #9 is prescribed Melatonin 5 mg-Take 1 tablet by mouth at bedtime; however, this medication was not administered to resident #9 on 6/20/23.

Resident #11 is prescribed Apixaban 5 mg-Take 1 tablet by mouth twice daily; however, this medication was only administered once on 6/26/23.

Resident #11 is prescribed Eliquis 5mg-Take 1 tablet by mouth twice a day; however, this medication was only administered once to resident #11 on 6/16/23.

Resident #13 is prescribed Tamsulosin 0.4 mg-Take 1 capsule by mouth once a day; however, this medication was not administered to resident #13 on 6/15/23.

Resident #13 is prescribed Tramadol 50 mg-Take 1 tablet by mouth twice a day; however, this medication was only given once to resident #13 on 6/15/23.

Resident #13 is prescribed Preservision Areds Chew Tabs-Chew 1 tablet by mouth twice daily; however, this medication has not been available in the home since approximately 5:00 pm on 6/15/23.

REPEAT VIOLATION: 8/1/2022, et. al.; 12/28/2022

Plan of Correction ***Accept [redacted] - 08/30/2023)***

• On 7/31/2023 Immediate action was taken by HWD to assess vitals for resident #3

• On 08/01/2023 Immediate action was taken by HWD to monitor vitals for resident's #2,3,4,5,7,8,9,11,and 14.

187d - Follow Prescriber's Orders (continued)

• On 8/05/2023 an audit was completed by HWD or Designee of all residents requiring sliding scale insulin. Record of documentation to be kept (Exhibit 25.A)
• On 08/05/2023 and education was provided by ED to HWD, PCD, MCD, Medical Records clerk and all MedTech staff on proper record keeping and MD orders in coordination with regulation 2600.187 Record of documentation to be kept. (Exhibit 25.B)
on 8/31/2023 an audit of all medication in community to be completed by ED, HWD, Medical records clerk, and personal care director to ensure all medications ordered for all residents are present in the community. documentation of audit to be kept.
•Beginning on 8/10/2023 an audit of proper instructions and dosage by HWD or Designee for 3 residents requiring sliding scale insulin weekly for 2 weeks followed by 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Record of documentation to be kept. (Exhibit 25.C)
on 8/31/2023 HWD or designee to complete audit of medication and mars for 5 residents daily for 2 weeks followed 5 residents weekly for 6 weeks followed by 5 residents monthly. documentation of audit to be kept.
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.
root cause, staff not properly documenting or timely documenting medication due to rushing through med pass.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented ([redacted] - 09/22/2023)

191 - Resident Right to Refuse

28. 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

Numerous residents in the home have not been educated on their right to question or refuse medication if they believe that there may be a medication error, to include residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 6/29/2023 Immediate action was taken to change verbiage in community resident rights portion of lease agreement to include residents right to question or refuse as it pertains to regulation 2600.191 and require a signature from resident and ED or designee upon learning of this right.
• On 8/01/2023, Ed educated all residents listed of their right to refuse or question medications based on regulation 2600.191 and acquired signature for verification. (DIRECTED: Copies of acknowledgements shall be kept in residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11's records.[redacted] 8/30/23)
• On 08/05/2023 an education was provided to Admission staff by ED on residents right to question or refuse in coordination with regulation 2600.191. Record of education to be kept (Exhibit 28.A)
on 5/11/2023 ED created new admission check list which includes resident right signage section. (DIRECTED: Copies of the completed new admission checklists shall be kept in each newly admitted resident's record. [redacted] 8/30/23).
on 8/31/2023 an education of new admission check list given by ED to admission staff.
• On 08/10/2023 an Audit of all residents by ED or Designee occurred to educate and obtain signatures in

191 - Resident Right to Refuse (continued)

coordination with regulation 2600.191 the residents right to question or refuse medications. Record of documentation to be kept. (Exhibit 28.B)

• Beginning 08/15/2023, ED or designee will Audit 2 resident charts for section (Z) weekly for 2 weeks followed by 1 resident chart weekly for 2 weeks followed by 1 resident chart biweekly for 2 weeks. record of documentation to be kept. (Exhibit 28.C)

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

root cause of issue was that company resident rights signature page lacked required information and has since been updated.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

224a - Preadmission Screen Form

29. 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, dated [redacted]/22, does not indicate if the home can meet resident #1's needs. This section of the form is blank.

Resident #6 was admitted to the home on [redacted]/23; however, no preadmission screening was completed.

Resident #7 was admitted to the home on [redacted]/23; however, no preadmission screening was completed.

Resident #9's preadmission screening, dated [redacted]/23, does not indicate if the home can meet resident #9's needs. This section of the form is blank.

Resident #11 was admitted to the home on [redacted]23; however, no preadmission screening was completed.

REPEAT VIOLATION 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 7/31/2023 Immediate action was taken by HWD to coordinate with Residents 1, 6, 7, 9, and 11's MD to make appropriate corrections as it pertains to regulation 2600.224.a.

DIRECTED: By 9/5/23: The administrator shall update residents #1 and #9's preadmission screenings to indicate if the home can meet the residents' needs. Copies of the updated preadmission screening forms shall be kept in residents #1 and #9's records. [redacted] 8/30/23

DIRECTED: By 9/5/23: The administrator shall complete preadmission screenings, in their entirety, for residents

224a - Preadmission Screen Form (continued)

#6, #7 and #11. Copies of the completed preadmission screening shall be kept in residents #6, #7 and #11's records. [redacted] 8/30/23).

on 5/11/2023 ED created a new admission check list to be utilized for all incoming residents. (DIRECTED: Copies of the completed new admission checklists shall be kept in each newly admitted resident's record. [redacted] 8/30/23).
on 8/31/2023 an Education provided by the ED to all admission staff on new admission check list. Documentation of education to be kept.
• On 8/05/2023 ED or designee completed an audit of all resident preadmission screenings for accuracy. Record of documentation to be kept. (Exhibit 29.A)
• On 8/05/2023 an Education was provided to all Admission staff on company preadmission required information, best practices and time line requirement in coordination with regulation 2600.224.a. Record of education to be kept. (Exhibit 29.B)
• Beginning 8/10/2023 an audit to be completed by ED or Designee of 5 residents preadmission screening weekly for 2 weeks followed by 3 residents weekly for 2 weeks followed buy 1 resident weekly for 2 weeks. record of documentation to be kept. (Exhibit 29.C) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents per month to ensure timely and complete preadmission screenings are completed. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

225a - Assessment 15 Days

30. 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

Resident #3 was admitted to the home on [redacted]/23; however, resident #3's assessment was not completed until 6/12/23.

Resident #6 was admitted to the home on [redacted]/23; however, resident #6's assessment was not completed until 6/15/23.

Resident #9 was admitted to the home on [redacted]/23; however, resident #9's assessment was not completed until 6/15/23.

REPEAT VIOLATION: 8/30/2022, et. al., 8/1/2022, et. al.

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Directed ([redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by HWD to investigate community assessment process. 7/31/2023 Education provided by ED to admissions staff on community resident move in check list. (DIRETED: Copies of the new admission checklists shall be kept in each newly admitted resident's record. [redacted] 8/30/23). Record of education to be kept. (Exhibit 30.A)

• On 7/31/2023 immediate action was taken by ED to education admission staff and HWD on Preadmission assessments vs initial assessments as it relates to regulation 2600.225.a to ensure proper assessment and move in procedures. Record of education to be kept. (Exhibit 30.B)

• On 8/05/2023 An audit of all residents by HWD or designee to check status of initial assessment vs preadmission assessment was performed and adjusted. Record of documentation to be kept. (Exhibit 30.C)

• Beginning 8/10/2023 ED or designee to complete audit for initial assessment and Preadmission assessment for 5 resident weekly for 2 weeks followed by 3 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Record of documentation to be kept (Exhibit 30.D) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents per month to ensure timely and complete assessments are completed. [redacted] 8/30/23).

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

The root cause was a mistake by new HWD in understanding the Preadmission assessment utilizing it in place of initial Assessment. Education has been given.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

225c - Additional Assessment

31. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #2's most recent assessment was completed on 6/14/23; however, resident #2's previous assessment was completed on 10/27/20.

Resident #4's most recent assessment was completed on 12/19/22; however, resident #4's previous assessment and was completed on 11/12/21.

Resident #8's most recent assessment, dated 2/22/23, does not include numerous diagnoses, to include Edema, Dermatitis, Hypertension and Tremors, as indicated on resident #8's most recent medical evaluation, which was signed by the medical professional who completed the form on 8/4/22.

Resident #10's most recent assessment, dated 6/8/23, does not include numerous diagnoses, to include Hypertension, Atrial Fibrillation and Osteoporosis, as indicated on resident #10's most recent medical evaluation, which was signed by the medical professional who completed the form on 5/4/22.

225c - Additional Assessment (continued)

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed ([redacted] - 08/30/2023)***

• On 8/01/2023 immediate action was taken by HWD to taken to review resident #2, 4, 8, and 10s assessments for further discrepancy.
• On 8/01/2023 immediate action was taken by HWD to properly assess resident #8 and #10 to include all diagnoses. (DIRECTED: By 9/1/23: Copies of the updated assessments shall be kept in resident #8 and #10's records. [redacted] 8/30/23).
• On 8/05/2023 an audit of all residents most recent assessments completed by HWD or designee checking for accuracy in coordination with regulation 2600.225.C. Record of documentation to be kept. (Exhibit 31.A)
• On 7/31/2023 an education was provided to HWD and Admissions staff on proper assessment timelines and required information in coordination with regulation 2600.225.C. Record of education to be kept (Exhibit 31.B)
• Beginning on 8/10/2023 an audit by HWD or designee of resident most recent assessments to be completed for 5 residents weekly for 2 weeks followed by 3 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Record of documentation to be kept. (Exhibit 31.C) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents per month to ensure timely and complete assessments are completed annually. LM 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.
Administrative and nursing turnover are the root cause for untimely assessment completion. (Playing catch up when starting)
Community utilizes system called YARDI to track all Assessment dates. This system is monitored daily by ED and HWD for upcoming and overdue assessments.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] 09/22/2023)

227a - Support Plan 30 Days

32. 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 #6 was admitted to the home on [redacted]/23; however, resident #6's initial support plan is undated, so it is unable to be determined if the support plan was completed within 30 days of admission to the home.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed ([redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by HWD or designee to update resident #6 support plan to include date of completion. (DIRECTED: By 9/1/23: A copy of resident #6's updated support plan shall be kept in resident #6's

227a - Support Plan 30 Days (continued)

record. [redacted] 8/30/23).
• On 8/01/2023 an audit completed by HWD or designee of all resident's initial support plans to check for discrepancies and inaccuracies completed. Record of documentation kept. (Exhibit 32.A)
on 5/11/2023 ED created new admission check list to ensure proper utilization of support plan upon resident coming to community. (DIRECTED: Copies of the completed new admission checklists shall be kept in each newly admitted resident's record. [redacted] 8/30/23). Documentation of education to be kept.
on 8/31/2023 ED to provide education on community new admission check list to all admission staff. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. LM 8/30/23).
• On 8/10/2023 an education was provided by ED to HWD, PCD, MCD, and admission staff and care staff on department requirements for support plan documentation in coordination with regulation 2600.227.a. Record of education to be kept (Exhibit 32.B)
• Beginning on 8/15/2023 an audit to be completed by HWD or designee of 5 resident support plans weekly for 2 weeks followed by 3 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Record of documentation to be kept. (Exhibit 32.C) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents per month to ensure timely and complete support plan are completed. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

227c - Support Plan Revision

33. 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

Resident #2's most recent assessment was completed on 6/14/23; however, resident #2's most recent support plan is undated.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed ([redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by HWD to update most recent assessment with correct information including proper date.
• On 8/01/2023 an education provided by ED to HWD and admission staff on support plan documentation requirements in coordination with 2600.227.c. Record of education kept (Exhibit 33.A)
• On 8/01/2023 an audit of all resident support plan checking for proper documentation and accuracy completed by HWD or designee. Record of documentation kept (Exhibit 33.B)
• Beginning on 8/10/2023 an audit completed by HWD or Designee to be completed for 4 residents weekly for 2 weeks followed by 2 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. (DIRECTED:

227c - Support Plan Revision (continued)

Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents per month to ensure timely and complete support plans are completed. [redacted] 8/30/23). Record of documentation to be kept. (Exhibit 33.C)

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented ([redacted] 09/22/2023)

227d - Support Plan Medical/Dental

34. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #8's most recent assessment, dated [redacted]/23, indicates resident #8 requires total physical assistance with drinking; however, resident #8's most recent support plan, dated 3/21/23, does not include the plan to meet this need. Also, resident #8's assessment indicates resident #8 has a moderate problem with agitation and minimal problem with aggression; however, resident #8's support plan does not include a plan to meet these needs. Resident #8's support plan just indicates the resident is "easily upset or unsettled" and that resident #8 is "violent, verbally or physically".

Resident #10's most recent support plan, dated [redacted]23, does not include the use of resident #10's enabler bar to turn and position [redacted] in bed. Also, resident #10's most recent assessment, dated [redacted]23, indicates resident #10 needs prompting/cueing assistance to use the telephone and needs total physical assistance with making and keeping appointments; however, resident #10's support plan does not include a plan to meet these needs.

REPEAT VIOLATION: 8/30/2022, et. al.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 8/01/2023 immediate action was taken by HWD or designee to address and update support plan needs for resident #8 and #10 in relations to resident assessment as outlined in regulation 2600.227.d. (DIRECTED: By 9/1/23: Copies of resident #8 and #10's updated support plans shall be placed in resident #8 and #10's records. [redacted] 8/30/23).

• On 08/01/2023 an audit by HWD or designee conducted of all residents to verify support plan meets needs of each resident based on their most recent assessment. Record of documentation to be kept. (Exhibit 34.A)

• On 8/05/2023 an education was provided by ED to HWD, Direct Care staff and admissions staff on support plans required information in tandem with resident assessment as it relates to regulation 2600.227.D) (Exhibit 34.B) (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 8/30/23).

• Beginning on 8/10/2023 an Audit to be completed by HWD or designee of resident support plan accuracy for 5 residents weekly for 2 weeks followed by 3 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Record of documentation to be kept. (Exhibit 34.C) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents per month to ensure timely and complete support plans

227d - Support Plan Medical/Dental (continued)

are completed. [redacted] 8/30/23).

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Support plan process for community works in tandem with community assessment. Needs are assessed at least twice yearly unless a change in condition triggers a new assessment. As this assessment is completed HWD utilized assessment to complete resident support plan. Resident support plan is presented to family and resident for review.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

227g -Support Plan Signatures

35. Requirements

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

Description of Violation

Resident #1's support plan, dated [redacted]/22, is not signed and dated by the assessor who completed resident #1's support plan. Also, resident #1's support plan is not signed by the resident and does not indicate if resident #1 was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #2's most recent support plan, which is undated, is not signed and dated by the assessor who completed resident #2's support plan. Also, resident #2's support plan does not include the date resident #2 signed the support plan.

Resident #3's support plan, dated [redacted]/23, is not signed and dated by the assessor who completed resident #3's support plan. Also, resident #3's support plan is not signed by the resident and does not indicate if resident #3 was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #4's support plan, dated [redacted]/22, is not signed and dated by the assessor who completed resident #4's support plan. Also, resident #4's support plan is not signed by the resident and does not indicate if resident #4 was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #5's support plan, dated [redacted]/22, is not signed and dated by the assessor who completed resident #5's support plan.

Resident #6's support plan, which is undated, is not signed and dated by the assessor who completed resident #6's support plan. Also, resident #6's support plan is not signed by the resident and does not indicate if resident #6 was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #7's support plan, which is undated, is not signed and dated by the assessor who completed resident #7's support plan.

Resident #8's support plan, dated [redacted]/23, is not signed and dated by the assessor who completed resident #8's support plan. Also, resident #8's support plan is not signed by the resident and does not indicate if resident #8 was unable to participate, declined to participate, refused to sign or was unable to sign.

227g -Support Plan Signatures (continued)

Resident #9's support plan, dated [redacted]/23, is not signed and dated by the assessor who completed resident #9's support plan. Also, resident #9's support plan is not signed by the resident and does not indicate if resident #9 was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #10's support plan dated, [redacted]23, is not signed and dated by the assessor who completed resident #10's support plan. Also, resident #10's support plan is not signed by the resident and does not indicate if resident #10 was unable to participate, declined to participate, refused to sign or was unable to sign.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by HWD, ED, PCD, and MCD, to update support plans appropriately were permitting. completed 7/31/2023 (DIRECTED: By 9/1/23: Copies of the signed support plans for residents #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10 shall be kept in each resident's record. [redacted] 8/30/23).
• On 08/01/2023 an audit by HWD or designee conducted of all residents to verify support plan meets needs of each resident based on their most recent assessment and signed by applicable parties. Record of documentation to be kept. (Exhibit 34.A)
• On 8/05/2023 an education was provided by ED to HWD, Direct Care staff and admissions staff on support plans required information in tandem with resident assessment as it relates to regulation 2600.227.D) (Exhibit 34.B) (DIRECTED; Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 8/30/23).
• Beginning on 8/10/2023 an Audit to be completed by HWD or designee of resident support plan accuracy and signatures for 5 residents weekly for 2 weeks followed by 3 residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Record of documentation to be kept. (Exhibit 34.C) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents per month to ensure support plans are signed by all applicable parties. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.
root cause for issue is turn over in administration and lack of oversight in transitional time.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

231b - Medical Evaluation

36. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #7 was admitted to the home's SDCU on [redacted]23; however, resident #7's medical evaluation does not include the date the resident was evaluated or the date the form was completed. These sections of the form are blank. Also, resident #7's medical evaluation does not indicate the need for resident #7 to be served in the SDCU.

231b - Medical Evaluation (continued)

Resident #11 was admitted to the home's SDCU on [redacted]23; however, resident #11's medical evaluation was completed on [redacted]/23. Also, resident #11's medical evaluation does not indicate the need for resident #11 to be served in the SDCU.

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by Memory Care Director or Designee to coordinate with resident #7 and #11's physician to update DME where appropriate. completed 7/31/2023 (DIRECTED: By 9/1/23: Copies of the completed medical evaluations for residents #7 and #11 shall be kept in their resident records. [redacted] 8/30/23).
on 5/11/2023 ED created a new admission check list for all incoming residents. (DIRECTED: Copies of the completed new admission checklists shall be kept in each newly admitted resident's record. [redacted] 8/30/23).
on 8/31/2023 ED provided education to all admission staff on New admission check list and ensuring all medical evaluations are completed in their entirety, within 60 days prior to admission in coordination with regulation 2600.231.b. documentation of education to be kept.
• On 8/01/2023 an audit of all SDCU resident's DME's by MCD or designee completed checking for accuracy and required information. Record of documentation to be kept. (Exhibit 36.A)
• On 8/05/2023 an education was provided by ED to MCD and MCC in SDCU on proper documentation and required information in DME in coordination with regulation 2600.231.B. Record of education to be kept. (Exhibit 37.B)
• Beginning 8/10/2023 an audit of required information on DME to be completed by MCD or designee for 3 SDCU residents weekly followed by 2 SDCU residents weekly for 2 weeks followed by 1 SDCU resident weekly for 2 weeks. Record of documentation to be kept. (Exhibit 37.C) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents from the SDCU per month to ensure timely and complete medical evaluations are completed, which includes ensuring the need for the resident to be served on the SDCU is documented on the medical evaluation. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

231c - Preadmission Screening

37. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #7 was admitted to the SDCU on [redacted]/23; however, no cognitive preadmission screening was completed.

Resident #11 was admitted to the SDCU on [redacted]/23; however, no cognitive preadmission screening was completed.

REPEAT VIOLATION: 8/1/2022, et. al.

231c - Preadmission Screening *(continued)*

Plan of Correction ***Directed (- 08/30/2023)***

• On 7/31/2023 immediate action was taken By ED to investigate why no cognitive preadmission was completed for SDCU residents 7 and 11.
on 8/01/2023 a cognitive preadmission screening was completed by MCD or designee for residents #7 and #11. (DIRECTED: Copies of the completed cognitive preadmission screenings shall be kept in resident #7 and #11's records. 8/30/23).
on 5/11/2023 ED created a new admission check list which ensures the completion of a cognitive preadmission screening. (DIRECTED: Copies of the completed new admission checklists shall be kept in each newly admitted resident's record. 8/30/23).
on 8/31/2023 ED provided an education on new admission check list to all admission staff. documentation of education to be kept.
• On 8/01/2023 an Audit by MCD of all SDCU resident's cognitive preadmission screenings completed to ensure proper requirements fulfilled by community. Record of documentation to be Kept (Exhibit 37.A)
• On 8/05/2023 an education was provided by ED to all SDCU Staff on community preadmission process and its requirement for cognitive preadmission screenings in coordination with regulation 2600.231.c. Record of education to be kept (Exhibit 37.B)
• Beginning on 8/10/2023 an audit by MCD or designee of resident cognitive preadmission screen and its accuracy to be completed for 5 SDCU residents weekly for 2 weeks followed by 3 SDCU residents weekly for 2 weeks followed by 1 SDCU residents weekly for 2 weeks. Record of documentation to be kept (Exhibit 37.C) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents from the SDCU per month to ensure timely and complete cognitive preadmission screenings are completed. 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented (- 09/22/2023)

231e - No Objection Statement

38. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #7 was admitted to the home's SDCU on /23; however, there is no documentation present indicating resident #7 and resident #7's designated person have not objected to the admission to the SDCU.

Resident #11 was admitted to the home's SDCU on /23; however, there is no documentation present indicating resident #11 and resident #11's designated person have not objected to the admission to the SDCU.

REPEAT VIOLATION: 8/1/2022, et. al.

231e - No Objection Statement *(continued)*

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by MCD to reach out and secure no objection documentation/signature from both resident #7 and #11's designated person. completed 7/31/2023

DIRECTED: By 9/5/23: The home shall obtain documentation from residents #7 and #11 indicating residents #7 and #11 have not objected to the admission to the SDCU. The docuentation shall be kept in resident #7 and #11's records. [redacted] 8/30/23).

on 5/11/2023 ED created a new admission check list for use with all incoming residents to the community. check list to ensure the no objections statement is signed by all applicable parties at time of admission for SDCU. (DIRECTED: Copies of the completed new admission checklists shall be kept in each newly admitted resident's record. [redacted] 8/30/23).
on 8/31/2023 ED provided education to all admissions staff on new admission check list and its relevance to no objections statements.
• On 8/01/2023 an education was provided by ED to HWD, MCD, and admission staff on the department's requirement for documentation of No objection from resident or residents designated person. Record of education to be kept (Exhibit 38.A)
• On 8/05/2023 an audit was conducted by MCD or designee of all SDCU resident's community file to ensure or obtain documentation of no objection. Record of documentation to be kept. (Exhibit 38.B)
• Beginning on 8/10/2023 an audit to be completed by MCD or designee for resident "no objection statements" for 5 SDCU residents weekly for 2 weeks followed by 3 SDCU residents weekly for 2 weeks followed by 1 SDCU resident weekly for 2 weeks. Record of documentation to be kept (Exhibit 38.C) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents from the SDCU per month to ensure documentation is present in resident records indicating residents and their designated persons have not objected to the admission to the home's SDCU. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

234a - Admission Support Plan

39. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #7 was admitted to the SDCU on [redacted]/23; however, resident #7's support plan is undated, so it is unable to be determined if the support plan was completed within 72 hour prior to admission or within 72 hours after admission.

Resident #11 was admitted to the SDCU on [redacted]/23; however, resident #11's support plan was not completed until [redacted]/23.

234a - Admission Support Plan (continued)

REPEAT VIOLATION: 8/1/2022, et. al.

Plan of Correction ***Directed [redacted] - 08/30/2023)***

• On 7/31/2023 immediate action was taken by MCD or designee to coordinate with Health and wellness director and update resident #7 and #11's support plan to accurately reflect requirements outlined in regulation 2600.234.a. including date of completion. completed 7/31/2023 (DIRECTED: Copies of resident #7 and #11's updated support plans shall be kept in their records. [redacted] 8/30/23).
on 5/11/2023 Ed created a new admission check list to ensure support plan is completed properly and in its entirety. (DIRECTED: Copies of the completed new admission checklists shall be kept in each newly admitted resident's record. [redacted] 8/30/23).
on 8/31/2023 Ed provided education for all admission staff on new admission check list ensuring all support plans are completed in their entirety within 72 hours prior to admission.. documentation of education to be kept.
• On 8/01/2023 an audit by MCD or designee of all SDCU resident support plans and their accuracy completed. Record of documentation to be kept. (Exhibit 39.B)
• On 8/01/2023 MCD coordinating with resident physicians and utilizing support plan audit updated SDCU resident support plans to meet requirements outlined by regulation 2600.234.a
• Beginning on 8/10/2023 an audit to be completed by MCD or designee of support plans for 5 SDCU residents weekly for 2 weeks followed by 3 SDCU residents weekly for 2 weeks followed by 1 resident weekly for 2 weeks. Record of documentation to be kept. (Exhibit 39.C) (DIRECTED: Immediately following the completion of the weekly audits, audits shall be completed for at least 5 residents from the SDCU per month to ensure timely and complete support plans are completed. [redacted] 8/30/23).
• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

Directed Completion Date: *09/20/2023*

Not Implemented [redacted] - 09/22/2023)

236 - Staff Training

40. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person A, hired on [redacted]/21, did not receive 6 hours of annual training related to dementia care and services during the 2022 training year. Direct care staff person A works in the SDCU.

Direct care staff person C, hired on [redacted]/21, did not receive 6 hours of annual training related to dementia care and services during the 2022 training year. Direct care staff person C works in the SDCU.

Plan of Correction ***Accept [redacted] - 08/30/2023)***

•On 8/01/2023 Immediate action was taken to assess all active SDCU employees in the community by ED, HWD, PCD and MCD to determine what employees required yearly staff trainings.
Staff person A no longer works for the Sheridan.

236 - Staff Training (continued)

On 9/12/2023 staff person C is scheduled to complete 6 hour dementia training through Relias in coordination with regulation 2600.236. documentation of education to be kept.

• As of 1/01/2023, All mandatory employee trainings including 6 hour dementia trainings made accessible via Relias online program.

• On 8/01/2023 an audit was conducted by ED or designee of all current staffs 12-month training requirements and dementia related trainings. Record of documentation to be kept. (Exhibit 8.A)

• On 8/05/2023 an education provided by ED to all Direct care staff on meeting 12-month Trainings and dementia training requirements outlined in regulation 2600.65 and 2600.236 was given. Record of education to be kept (Exhibit 8.B)

• On 8/10/2023 An Audit of employee Trainings requirements to be completed by ED or designee for 4 employees twice weekly for 2 weeks followed by once weekly for 1 week followed by once biweekly for 2 weeks. Record of documentation to be kept. (Exhibit 8.C)

• On going measures to be discussed by ED and MGMT team at monthly Quality Assurance meeting beginning 9/7/2023. Records of meeting to be kept.

New employees must work for a minimum of 30 days on personal care side of the community before taking the 6 hour dementia training. Once taken education is verified by Scheduler with ED before scheduling community trainings in SDCU.

During onboarding new staff are given a Relias login. In Relias monthly trainings are designated for each staff member. Email and text alerts are communicated to staff. Any individual past due of mandatory DHS required trainings is removed from the schedule until completion.

ED is able to monitor Relias trainings of all employees monthly. Utilizing Quality assurance monthly meeting to discuss with departments.

Employees are required to find time either at work from home to complete required trainings. If required trainings are completed from home. Staff is compensated their hourly rate for doing so. ED is capable of monitoring date and time of training.

Licensee's Proposed Overall Completion Date: *09/21/2023*

Not Implemented [redacted] - 09/22/2023)