CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: July 24, 2023

Ms. Colleen Roy, President/COO
Northland Heights LLC
10 Lafayette Square, Suite 1900
Buffalo, New York 14203

RE: Northland Heights
4859 Mcknight Road
Pittsburgh, Pennsylvania 15237
License/COC #: 450841

Dear Ms. Roy:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on April 4, 2023, April 5, 2023, April 6, 2023, May 10, 2023, May 11, 2023, and June 2, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), mistreatment or abuse of residents being cared for in the facility, 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 REVOKES your certificate of compliance (license number 450840) dated February 4, 2023 – February 4, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. 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 FIRST PROVISIONAL license is enclosed and is valid from July 24, 2023 to January 24, 2024.

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

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2800 (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 2800 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	42	$5	$210	5 calendar days from mailing date of this letter
17	II	42	$5	$210	5 calendar days from mailing date of this letter
25(b)	II	42	$5	$210	5 calendar days from mailing date of this letter
41(e)	II	42	$5	$210	5 calendar days from mailing date of this letter
103(f)	II	42	$5	$210	5 calendar days from mailing date of this letter
141(a)	II	42	$5	$210	5 calendar days from mailing date of this letter
141(b)(1)	II	42	$5	$210	5 calendar days from mailing date of this letter
183(d)	II	42	$5	$210	5 calendar days from mailing date of this letter
184(a)	II	42	$5	$210	5 calendar days from mailing date of this letter
187(b)	II	42	$5	$210	5 calendar days from mailing date of this letter
187(d)	II	42	$5	$210	5 calendar days from mailing date of this letter
191	II	42	$5	$210	5 calendar days from mailing date of this letter
224(a)	II	42	$5	$210	5 calendar days from mailing date of this letter
225(a)	II	42	$5	$210	5 calendar days from mailing date of this letter

227(c)	II	42	$5	$210	5 calendar days from mailing date of this letter
231(c)	II	42	$5	$210	5 calendar days from mailing date of this letter
231(d)	II	42	$5	$210	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:

Lestia Fetzer, 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: 717-214-1304

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
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: Gene Cuccarese, Office of General Counsel
Theresa Hartman, Bureau Director
Sheila Page, Director of Operations
Brent Sutherland, Regional Director

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

Facility Information

Name: *NORTHLAND HEIGHTS* **License #**: *45084* **License Expiration**: *02/04/2024*

Address: *4859 MCKNIGHT ROAD, PITTSBURGH, PA 15237*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *NORTHLAND HEIGHTS LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-1* **Date**: *01/21/2020* **Issued By**: *Ross Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *62* **Waking Staff**: *47*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/06/2023*

Inspection Dates and Department Representative

04/04/2023 - On-Site:
04/05/2023 - On-Site:
04/06/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *123* **Residents Served**: *46*

Special Care Unit

In Home: *Yes* **Area**: *2nd floor* **Capacity**: *19* **Residents Served**: *3*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *44*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *16* **Have Physical Disability**: *1*

Inspections / Reviews

04/04/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/22/2023*

04/26/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/01/2023*

Reviewer: *Larry Mazza* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/02/2023*

05/05/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/01/2023*

07/06/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/01/2023*

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

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence 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 assisted living residence.

Description of Violation

On 4/4/23, the current license inspection summaries, dated 1/6/23, 8/11/22, 2/25/22 and 1/11/22, were not posted in a conspicuous and public place in the residence.

On 4/4/23, a copy of the 55 Pa. Code Chapter 2800 regulations were not posted in a conspicuous and public place in the residence.

Plan of Correction ***Accept - 05/03/2023)***

Current license inspection dated 1/6/23, 8/11/22, 2/25/22 and 1/11/22 were posted on 4/4/23 in a conspicuous and public place. Administrator to monitor weekly for compliance beginning 4/10/23. Administrator will do a visual inspection for all inspection summaries.

Licensee's Proposed Overall Completion Date: *05/03/2023*

Implemented - 07/06/2023)

16c Incident reporting

2. Requirements

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

Description of Violation

On 3/7/23 at approximately 3:30PM, 2 of resident #7's Oxycodone-5mg medication cards went missing from the residence and law enforcement was contacted; however, this incident was not reported to the Department until 3/10/23.

REPEAT VIOLATION: 11/1/2022, 1/11/2022, et. al.

Plan of Correction ***Accept - 05/03/2023)***

Administrator reviewed guidelines of regulation 2800.16 with new DON and leadership team on 4/5/23. Documentation of training will be kept in employee files. Administrator will maintain a reportable incident file that will document incident reporting. Daily monitoring of all incidents began on 4/6/23 by DON and Administrator. All staff persons were re-educated on all reportable incidents and conditions specified in 2800.16a, as well as the home's reporting procedures to ensure timely reporting to the Department on 4/26 and 4/28. Documentation of training will be kept in accordance with 2800.65L

Licensee's Proposed Overall Completion Date: *05/03/2023*

Not Implemented - 07/06/2023)

17 Record confidentiality

3. Requirements

2800.

17 Record confidentiality *(continued)*

17. Confidentiality of Records - 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 4/4/23 at 11:20 AM, a binder labeled, "Resident Care Plans" was unlocked, unattended and accessible at the 2nd floor nursing station, which included the assessments and support plans for residents #1, #2, and #3.

On 4/6/23 at 11:11 AM, resident #2's care binder was unlocked, unattended and accessible at the 2nd floor nursing station, which included resident #2's face sheet, a physician order, dated 12/20/22 and nursing notes, dated 2/1/23.

REPEAT VIOLATION: 1/11/2022, et. al.

Plan of Correction ***Accept (- 05/03/2023)***

Binders were removed on 4/7/23. Administrator has reeducated the leadership team on confidentiality of records on 4/7/23. DON reeducated nursing staff on 4/7/23 and included outside agencies (hospice). Resident care plan binders were removed from nursing floors on 4/6/23 and will be maintained in a medical record room accessible to staff providing services, residents or resident designated person. Documentation of training will be kept in accordance with 2800.65L.DON will check the medical records room daily beginning on 4/8/23. The nursing units will be monitored weekly by DON, ADM or designee beginning on 5/1/23.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Not Implemented - 07/06/2023)

25b Contract signatures and renewal

4. Requirements

2800.
25b . The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

Resident #1's resident-residence contract, dated 12/30/22, is not signed by resident #1.

Resident #4's resident-residence contract, dated 1/13/23, is not signed by resident #4.

REPEAT VIOLATION: 1/11/2022, et. al.

Plan of Correction ***Directed - 05/03/2023)***

Resident #1 and #4 contract for admission were signed on 4/6/23. (DIRECTED: Within 72 hours of receipt of the plan of correction: Copies of the signed resident-residence contracts shall be kept in residents #1 and #4's records. 5/5/23). All resident contracts were audited for proper signatures on 4/10/23 by , LPN. Administrator educated leadership team on regulations 2800.25b on 4/7/23. Documentation of training will be kept in accordance with 2800.65L. Monitoring of admission paperwork will be maintained by new Business Office Manager to ensure contracts are completed and signed by all applicable parties within 24 hours of admission. A new admission checklist was created on 4/24/23. (DIRECTED: The new admission checklist shall be implemented by 5/10/23. All staff persons involved in the admission process shall be educated on the new checklist by 5/10/23. Documentation of

25b Contract signatures and renewal (continued)

the education shall be kept. ██ 5/5/23)

Directed Completion Date: *05/10/2023*

Not Implemented (██ 07/06/2023)

26b Quality management plan content

5. Requirements

2800.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
3. Staff person training.

Description of Violation

The most recent quality management review, conducted on 4/11/22, did not include a review of the following topics:

- *The reportable Incident and condition reporting procedures*
- *Staff person training*

Plan of Correction ***Directed (██ - 05/03/2023)***

Quality management plan will include all items specified in 2800.26b, which include a review of reportable incidents and staff training. Documentation of the review will be kept. ██ review was completed on 4/7/23. A checklist was implemented, minutes were taken and core curriculum has been followed per each tag item. Administrator will monitor monthly for compliance for 3 months and then quarterly. (DIRECTED: The administrator audits shall begin on 5/8/23 to ensure a quality management review is conducted at least annually and includes a review of all topics specified in 2800.26b during each quality management review. Documentation of all quality management reviews shall be kept, which includes the date of the review, who attended and what topics were discussed. ██ 5/3/23).

Directed Completion Date: *05/08/2023*

Not Implemented ██ - 07/06/2023)

41e Signed statement

6. Requirements

2800.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's resident-residence contract, dated 12/30/22, does not include a statement signed by resident #1 acknowledging receipt of a copy of the resident rights and complaint procedures.

Resident #4's resident-residence contract, dated 1/13/23, does not include a statement signed by resident #4 acknowledging receipt of a copy of the resident rights and complaint procedures.

REPEAT VIOLATION: 1/11/2022, et. al.

Plan of Correction ***Directed (██ - 05/05/2023)***

Resident #1 and #4 resident rights and compliance documentation were signed on 4/5/23 and placed in their files.

41e Signed statement (continued)

All resident's contracts reviewed for compliance of required signed statement by resident acknowledging receipt of a copy of the resident rights and complaint procedures on 4/26 & 4/27 by [redacted] nurse and [redacted],LPN. DON and Sales Manager were reeducated on signed statement requirements on 4/26/23. An admission checklist will be utilized and all paperwork will be signed within 48 hrs. of admission. (DIRECTED: The new admission checklist shall be implemented by 5/10/23. All staff persons involved in the admission process shall be educated on the new checklist by 5/10/23. Documentation of the education shall be kept. [redacted] 5/5/23) Administrator to monitor resident files monthly beginning 5/1/23

Directed Completion Date: *05/10/2023*

Not Implemented [redacted] - 07/06/2023)

42s Privacy - self/possessions

7. Requirements

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

Description of Violation

The residence is video recording in numerous common areas on all floors of the residence, to include the following areas:

- *The activities room near the 1st floor main lobby*
- *The 1st floor enclosed porch*
- *The 2nd floor hallway, which is recording the doorways of numerous resident living units, to include living units #201, #203, #204, #207 and #209*
- *The 5th floor hallway, which is recording the doorways of numerous resident living units, to include living units #501, #512, #515 and #516*
- *The 6th floor hallway, which is recording the doorways of numerous resident living units, to include living units #601, #602, #603 and #605*

At admission, residents #4 and #5 were not informed that video recording is occurring in numerous areas of the residence.

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

Video recording will be removed from all hallways on the 2nd, 5th, and 6th floors and common areas. Residents 4 and 5 were informed that video recording is taking place in numerous areas and consent obtained on 4/20/23. Resident records were audited for compliance by Business Office Manager on 4/27/23. An addendum was added to all resident files on 5/1/23. Maintenance Director will monitor weekly to ensure cameras are only recording in the allowed areas and that signs remain posted. (DIRECTED: The weekly audits shall begin on 5/10/23. [redacted] 5/5/23). All new residents will be informed of video recording upon move in.

DIRECTED: By 5/10/23: The administrator shall review all of the residence's cameras to ensure video recording is only occurring in interior areas completely inaccessible to residents, such as medication and supply storage areas, as well as the residence's entrances and exits and the interior corridors leading to entrances and exits. [redacted] 5/5/23

Directed Completion Date: *05/10/2023*

42s Privacy - self/possessions *(continued)*

Not Implemented [redacted] - 07/06/2023)

51 Criminal background checks

8. Requirements

2800.
51. Criminal background checks
    a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).
    b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

Staff person A, the residence's administrator, has worked for the legal entity in New York since May, 2013. In November, 2022, staff person A moved to Pennsylvania and was transferred to the residence as the administrator. However, a Pennsylvania criminal background check, or a Federal Bureau of Investigation (FBI) check were not completed for staff person A.

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

Federal background check was completed on 4/15 and 4/17. Staff records were reviewed to ensure a PA background check was completed for all current staff persons, as well as a FBI check for all staff persons who have not been a PA resident for 2 consecutive years at the time of hire on 4/21/23. BOM or ADM will facilitate all background checks on new employees prior to hiring and will utilize a new hire checklist beginning 5/1/23. (DIRECTED: All staff persons involved in the hiring process shall be educated on the new checklist by 5/10/23. Documentation of the education shall be kept. [redacted]/23). Administrator will audit for compliance weekly for 3 months beginning 5/1/23.

Directed Completion Date: *05/10/2023*

Not Implemented [redacted] - 07/06/2023)

53a Admin. qualifications

9. Requirements

2800.
53.a. The administrator shall have one of the following qualifications:
1. A license as an RN from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.
2. An associate's degree or 60 credit hours from an accredited college or university in a human services field and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.
3. An associate's degree or 60 credit hours from an accredited college or university in a field that is not related to human services and 2 years, in the prior 10 years, of direct care or administrative experience in a health care or human services field.
4. A license as an LPN from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.
5. A license as a nursing home administrator from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.
6. With the exception of administrators qualified under § 2600.53(a)(5) (relating to qualifications and responsibilities of administrators), experience as a personal care home administrator, if the following requirements are met:
    i. Employed as a personal care home administrator for 2 years prior to January 18, 2011.

53a Admin. qualifications *(continued)*

ii. Completed the administrator training requirements and pass the Department-approved competency-based training test in § 2800.64 (relating to administrator training and orientation) by January 18, 2012.

Description of Violation

No qualifications specified in 2800.53a were present for staff person A, the residence's administrator.

Plan of Correction ***Directed - 05/05/2023)***

A copy of credentialing diplomas are being obtained. Diploma will be provided as soon as it is received. All other documentation of qualifications were received by surveyor on 4/5/23.

DIRECTED: By 5/30/23: The administrator shall obtain a copy of their qualifications specified in 2800.53a. Copies of the qualifications shall be kept in the administrator's record. 5/5/23.

Directed Completion Date: *05/30/2023*

Not Implemented - 07/06/2023)

54a Direct care staff quals

10. Requirements

2800.

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

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

Description of Violation

Direct care staff person B, hired on , does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed (- 05/05/2023)***

Qualifications for staff person B was verified on 4/10/23. (DIRECTED: By 5/8/23: A copy of staff person B's qualifications specified in 2800.54a shall be placed in staff person B's record. 5/5/23). All staff files will be reviewed for compliance regarding qualifications by 5/31/23. (DIRECTED: Copies of all direct care staff person qualifications specified in 2800.54a shall be kept in each direct care staff person's record. 5/5/23). Business Office Manager educated on obtaining required qualifications for employees on 4/ All staff persons involved in the hiring process shall be educated on the new checklist by 5/5/23. Checklist implementation began on 5/1/23. Documentation of the staff training shall be kept in accordance with 2800.65L. Administrator responsible for compliance and will audit new employee files weekly for 3 months beginning 5/8/23.

Directed Completion Date: *05/31/2023*

Not Implemented - 07/06/2023)

63a First Aid/CPR 1:35

11. Requirements

2800.

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

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

Description of Violation

On 4/3/23 from approximately 11:00 PM through 5:00 AM, only 1 staff person trained in first aid and certified in obstructed airway techniques and CPR was present in the residence. On this day, 46 residents were present in the residence.

On 4/5/23 from approximately 11:00 PM through 5:00 AM, there were no staff persons trained in first aid and certified in obstructed airway techniques and CPR present in the residence. On this day, 46 residents were present in the residence.

Plan of Correction ***Directed (- 05/05/2023)***

DON educated on need to have one staff person for every 35 residents trained in first aid and certified in obstructed airway techniques and CPR present in the residence on 4/6/23. DON and ADM will review the direct care staffing schedule daily to ensure for every 35 residents, there is at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times. (DIRECTED: The daily review of the direct care staffing schedule conducted by the DON/administrator shall begin on 5/8/23. 5/5/23). Next QM meeting will be 5/8/23. Documentation of the quality management reviews will be kept. Training is scheduled on May 4, 2023 for all expired and unexpired staff. Sessions will be offered quarterly and documented by DON. DON responsible for monitoring compliance.

Directed Completion Date: *05/08/2023*

Not Implemented (- 07/06/2023)

64a Initial admin training

12. Requirements

2800.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
1. An orientation program approved and administered by the Department.

Description of Violation

No documentation was present indicating staff person A, the residence's administrator, has completed the orientation program approved and administered by the Department.

Plan of Correction ***Accept (- 05/05/2023)***

Administrator registered on 5/2/23 for orientation to be completed on 5/15/23. The successful completion of the orientation program will be kept in the administrator's record.

Licensee's Proposed Overall Completion Date: *05/16/2023*

Implemented (- 07/06/2023)

65a Fire Safety-1st day

13. Requirements

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

65a Fire Safety-1st day *(continued)*

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.

Description of Violation

Direct care staff person B, hired on [redacted], did not receive training on any of the topics specified in 2800.65a.

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

Direct care staff person B received training on all topics specified in 2800.65a on 5/1/23. Documentation of education provided to staff person B will be kept in accordance with 2800.65L. All employee records will be audited for required trainings and completed by 5/31/2023 by BOM. All staff persons involved in the hiring process shall be educated on the new checklist by 5/5/23. Checklist implementation began on 5/1/23. All direct care staff will be educated on fire safety 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. Administrator is responsible for compliance and will audit weekly for 3 months beginning 5/31/23. Documentation of the staff training shall be kept in accordance with 2800.65L.

DIRECTED: Beginning on 5/8/23: The administrator shall ensure staff person training is reviewed during each of the residence's quality management meetings. Documentation of the quality management reviews shall be kept, which includes the date of the review, the names of the staff persons who participated and the meeting minutes. [redacted] 5/5/23

Directed Completion Date: *05/31/2023*

Not Implemented [redacted] - 07/06/2023)

65g Initial direct care training

14. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs

65g Initial direct care training *(continued)*

iii. Personal hygiene.
iv. Care of residents with mental illness, neurological impairments, an intellectual disability and other mental disabilities.
v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
vi. Implementation of the initial assessment, annual assessment and support plan.
vii. Nutrition, food handling and sanitation.
viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the residence.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. The signs and symptoms of infections and infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the residence.
xvii. Behavioral management techniques.
xviii. Understanding of the resident's assessment and how to implement the resident's support plan.
xix. Person-centered care and aging in place.

Description of Violation

Direct care staff person B, hired on [redacted], did not complete any of the 18 hours of training specified in 2800.65g. Direct care staff person B has worked unsupervised in the residence on numerous occasions, to include from 11:00 PM–7:00 AM on 3/13/23 and 3/14/23.

Direct care staff person C, hired on 8/2/22, did not complete any of the 18 hours of training specified in 2800.65g. Direct care staff person C has worked unsupervised in the residence on numerous occasions, to include from 7:00 AM-3:00 PM on 3/13/23, 3/14/23, 3/15/23 and 3/17/23.

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

All direct care staff will be compliant with 18 hours of training for regulation 2800.65g by 5/31/23. Direct care C is no longer employed at the facility. Documentation of the education will be kept in accordance with 2800.65L. All staff persons involved in the hiring process shall be educated on the new checklist by 5/5/23. Checklist implementation began on 5/1/23.. Monthly monitoring for compliance will be completed by administrator. (DIRECTED: The monthly monitoring by the administrator shall begin on 5/15/23. LM 5/5/23). Documentation of the staff training shall be kept in accordance with 2800.65L.
Plan of Correction

DIRECTED: By 5/15/23: Direct care staff person B shall complete 18 hours of training, which includes all topics specified in 2800.65g. Documentation of the education shall be kept in staff person B's record in accordance with 2800.65L. Direct care staff person B shall not perform unsupervised ADL services to residents until successful completion of all training requirements specified in 2800.65g. [redacted] 5/5/23).

DIRECTED: Beginning on 5/8/23: The administrator shall ensure staff person training is reviewed during each of the residence's quality management meetings. Documentation of the quality management reviews shall be kept, which includes the date of the review, the names of the staff persons who participated and the meeting minutes. [redacted] 5/5/23

Directed Completion Date: *05/31/2023*

65g Initial direct care training *(continued)*

Not Implemented ██ - 07/06/2023)

65h 16 hrs annual training

15. Requirements

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

Description of Violation

Direct care staff person D, hired on ██, received only 10 hours of annual training during the 2022 training year.

Plan of Correction ***Directed (██ - 05/05/2023)***

Staff person D will make up the 6 hours from last year by 5/31/23. (DIRECTED: Documentation of staff person D's training shall be kept in accordance with 2800.65L. ██ 5/5/23). All direct care staff will be compliant with 16 hours of training for regulation 2800.65g by 5/31/23. Monthly monitoring for compliance will begin on 5/1/23 by administrator. Staff training will be reviewed during the home's QM meetings. Next QM meeting will be 5/8/23. The home currently has a 16 hour training plan to be implemented by the new DON and BOM beginning 5/1/23.

DIRECTED: Beginning on 5/8/23: The administrator shall ensure staff person training is reviewed during each of the residence's quality management meetings. Documentation of the quality management reviews shall be kept, which includes the date of the review, the names of the staff persons who participated and the meeting minutes. ██ 5/5/23

DIRECTED: By 5/15/23: The administrator shall review the home's staff training plan to ensure all items specified in 2800.66b are present. The staff training plan shall be reviewed by the administrator monthly to ensure all direct care staff persons receive at least 16 hours of annual training relating to their job duties during each training year. Documentation of the staff training plan shall be kept. ██ 5/5/23

Directed Completion Date: *05/31/2023*

Not Implemented ██ - 07/06/2023)

65i Training topics

16. Requirements

2800.
65.i. 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, cognitive and neurological 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. Assisted living service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence.

65i Training topics *(continued)*

Description of Violation

Direct care staff person D, hired on 2/20/20, did not receive training on the following topics during the 2022 training year:

- *Medication self-administration training*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan*
- *Care for residents with mental illness or intellectual disability*

Direct care staff person E, hired on [redacted], did not receive training on the following topics during the 2022 training year:

- *Medication self-administration training*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan*
- *Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration*
- *Care for residents with mental illness or intellectual disability*

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

Direct care staff D will make up mandatory training topics by 5/31/23. (DIRECTED: Documentation of staff person D's training shall be kept in accordance with 2800.65L. [redacted] 5/5/23). Direct care staff E retired and no longer works at the home. All mandatory training sessions will be completed by 5/31/23. A new med tech training course is scheduled for May 15-31st to ensure competency. Staff training will be reviewed during the home's QM meetings. Next QM meeting will be 5/8/23.DON and Administrator will monitor monthly for compliance beginning 6/1/23.The home currently has a 16 hour training plan to be implemented by the new DON and BOM to include all the topics specified in 2800.65i beginning 6/1/23.

DIRECTED: Beginning on 5/8/23: The administrator shall ensure staff person training is reviewed during each of the residence's quality management meetings. Documentation of the quality management reviews shall be kept, which includes the date of the review, the names of the staff persons who participated and the meeting minutes. [redacted] 5/5/23

DIRECTED: By 5/15/23: The administrator shall review the home's staff training plan to ensure all items specified in 2800.66b are present. The staff training plan shall be reviewed by the administrator monthly to ensure all direct care staff persons receive training on all topics specified in 2800.65i during each training year. Documentation of the staff training plan shall be kept. [redacted] 5/5/23

Directed Completion Date: *05/31/2023*

Not Implemented ([redacted] 07/06/2023)

65j Annual training content

17. Requirements

2800.

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

65j Annual training content *(continued)*

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—10225.708).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Direct care staff person D, hired on [redacted], did not receive training on the following topics during the 2022 training year:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations*

Direct care staff person E, hired on 1[redacted], did not receive training on the following topics during the 2022 training year:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations*

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

Direct care staff D will make up mandatory training topics by 5/31/23. (DIRECTED: Documentation of staff person D's training shall be kept in accordance with 2800.65L. [redacted] 5/5/23). Direct care staff E retired and no longer works at the home. All mandatory training sessions will be completed by 5/31/23. All staff will receive fire safety training by 5/31/23 and annually thereafter. Administrator is responsible and will monitor monthly for compliance beginning 6/1/23. Records will be kept accurate with date and times of training , length of training, who provided the training for each employee. Staff training will be reviewed during the home's QM meetings. Next QM meeting will be 5/8/23. DON and Administrator will monitor monthly for compliance beginning 6/1/23.The home currently has a 16 hour training plan to be implemented by the new DON and BOM to include all the topics specified in 2800.65i beginning 6/1/23.

DIRECTED: Beginning on 5/8/23: The administrator shall ensure staff person training is reviewed during each of the residence's quality management meetings. Documentation of the quality management reviews shall be kept, which includes the date of the review, the names of the staff persons who participated and the meeting minutes. [redacted] 5/5/23

DIRECTED: By 5/15/23: The administrator shall review the home's staff training plan to ensure all items specified in 2800.66b are present. The staff training plan shall be reviewed by the administrator monthly to ensure all staff persons receive training on all topics specified in 2800.65j during each training year. Documentation of the staff training plan shall be kept. [redacted] 5/5/23

Directed Completion Date: *06/01/2023*

Not Implemented ([redacted] 07/06/2023)

69 Dementia training

18. Requirements

2800.

69 Dementia training *(continued)*

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Direct care staff person D, hired on [redacted] only received 1 hour of dementia training during the 2022 training year.

Direct care staff person E, hired on 1[redacted], only received 1 hour of dementia training during the 2022 training year.

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

Direct care staff D will make up mandatory training topics by 5/31/23. (DIRECTED: Documentation of staff person D's training shall be kept in accordance with 2800.65L.[redacted] 5/5/23). Direct care staff E retired and no longer works at the home. All new staff will receive four hours of training within first 30 days of hire and 2 hours annually. To be monitored by DON and ADM monthly. Administrator is responsible and will monitor monthly for compliance beginning 6/1/23. Records will be kept accurate with date and times of training , length of training, who provided the training for each employee. Staff training will be reviewed during the home's QM meetings. Next QM meeting will be 5/8/23. DON and Administrator will monitor monthly for compliance beginning 6/1/23. All administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers will receive at least 2 hours of dementia training each year. The home currently has a 16 hour training plan to be implemented by the new DON and BOM to include all the topics specified in 2800.65i beginning 6/1/23.

DIRECTED: BY 5/10/23: The administrator shall develop and implement a new hire checklist to ensure all newly-hired administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers receive at least 4 hours of dementia-specific training within 30 days of hire. Documentation of the education shall be kept in accordance with 2800.65L.[redacted] 5/5/23

DIRECTED: By 5/31/23: The administrator will review the records of all current administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers to ensure each staff person has received at least 4 hours of dementia-specific training within 30 days of hire. [redacted] 5/5/23

DIRECTED: By 5/15/23: The administrator shall review the home's staff training plan to ensure all items specified in 2800.66b are present. The staff training plan shall be reviewed by the administrator monthly to ensure all administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers receive at least 2 hours of dementia-specific training annually during each training year. Documentation of the staff training plan shall be kept in accordance with 2800.65L.[redacted] 5/5/23

Directed Completion Date: *05/31/2023*

Not Implemented [redacted] - 07/06/2023)

88a Floors, walls, ceilings, windows, doors

19. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 4/4/23 at approximately 11:15 AM, the lock was inoperable on the door leading to the 2nd floor special care unit

88a Floors, walls, ceilings, windows, doors (continued)

(SCU) courtyard/patio.

Plan of Correction ***Accept ███ - 05/05/2023)***

The maintenance director shall monitor the entire home monthly to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards beginning 5/1/23. Staff persons were educated on the home's procedures for reporting items which need repaired or replaced on 4/28/23 Documentation of the training will be kept in accordance with 2800.65L. Lock on special floor care unit was fixed on 4/4/23.

Licensee's Proposed Overall Completion Date: *05/03/2023*

Implemented ███ - 07/06/2023)

91 Telephone Numbers

20. Requirements

2800.

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

Description of Violation

On 4/4/23, there were no emergency telephone numbers posted on or by the telephone in living unit #508.

Plan of Correction ***Accept ███ - 05/05/2023)***

Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline were posted for #508 on 4/7/23 and by all telephones in occupied rooms on 4/28/23. All telephones with an outside line were checked on 4/28/23. Maintenance Director will monitor weekly for compliance beginning 5/1/23.

Licensee's Proposed Overall Completion Date: *05/03/2023*

Not Implemented ███ - 07/06/2023)

101j5 Bedside table/shelf

21. Requirements

2800.

101.j. Each resident shall have the following in the living unit:

5. A bedside table or a shelf.

Description of Violation

On 4/4/23, no bedside table or shelf was present next to resident #6's bed.

Plan of Correction ***Accept ███ - 05/05/2023)***

A bedside table was placed next to #6's bed on 4/4. All other rooms were checked for compliance on 4/6/23 by Maintenance Director. Maintenance Director will check monthly for room compliance beginning on 5/31/23.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Implemented ███ - 07/06/2023)

103f Fridge/Freezer Temps

22. Requirements

2800.

103f Fridge/Freezer Temps *(continued)*

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 4/4/23 at 11:12 AM, no thermometer was present in the freezer of the 2nd floor SCU refrigerator/freezer.

REPEAT VIOLATION: 1/11/2022, et. al.

Plan of Correction ***Accept - 05/05/2023)***

Thermometer was placed in freezer on 4/5/23. All other refrigerators and freezers were checked for an operable thermometer on 4/6/23. Daily monitoring of all coolers and freezers will be done for 3 months then weekly thereafter to ensure an operable thermometer is present and documentation of the temperatures are kept by new Culinary Director beginning 5/1/23. All staff persons were reeducated on the regulation on 4/6/23 by administrator. Documentation of education will be kept in accordance with 2800.65L

Licensee's Proposed Overall Completion Date: *05/03/2023*

Not Implemented - 07/06/2023)

103g Storing food

23. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 4/4/23 at 10:45 AM, numerous food items were opened and unsealed in the kitchen breakfast freezer, to include the following:

- *(2) 4 pound bags of mixed vegetables*
- *A paper bag of approximately 24 potato tater tots*
- *A 10 pound box of eggplant cutlets*
- *A 18.9 pound box of meat lovers stromboli*

Plan of Correction ***Accept (- 05/05/2023)***

All food items were labeled and stored appropriately in closed sealed containers on 4/4/23 at 4pm. Dietary staff reeducated on proper storage of food on 4/5/23. Monitoring will be done daily by new Culinary Director or designee on 5/1/23.

Licensee's Proposed Overall Completion Date: *05/03/2023*

Not Implemented - 07/06/2023)

107c Food/water – 3 day supply

24. Requirements

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

Description of Violation

On 4/4/23 through 4/7/23, the residence served 46 residents, requiring a minimum of 138 gallons of emergency drinking water for a 3-day supply; however, there were only approximately 11 gallons of emergency drinking water available on-site. The residence does not have a contractual agreement with a vendor to deliver drinking water in the

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

event of an emergency.

Plan of Correction ***Accept ■ - 05/05/2023)***

150 gallons of water were delivered on 4/5/23. Water supply will be monitored weekly by new Culinary Director on 5/1/23.

Licensee's Proposed Overall Completion Date: *05/03/2023*

Implemented ■ - 07/06/2023)

131f Fire extinguisher inspection

25. Requirements

2800.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 4/4/23, numerous fire extinguishers within the residence have not been inspected an approved by a fire safety expert since March, 2022, to include the following:

- *The fire extinguisher near the elevator in the basement*
- *The fire extinguisher near the 1st floor men's bathroom*
- *The fire extinguisher located at the 5th floor nursing station*
- *The fire extinguisher near living unit #515*

Plan of Correction ***Directed ■ - 05/05/2023)***

All fire extinguishers were inspected on 4/5/23 by Johnson Controls. A new contract for annual inspection was signed on 5/1/23 by Maintenance Director and Johnson Controls. Monthly monitoring will be tracked by MD beginning 5/1/23.

DIRECTED: By 5/15/23: The maintenance director shall ensure the date of the inspection is present on each of the home's fire extinguishers.■ 5/23

Directed Completion Date: *05/15/2023*

Not Implemented ■ - 07/06/2023)

132c Fire drill records

26. Requirements

2800.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The residence has not documented any monthly fire drills since the fire drill conducted on 9/31/22 at 9:53 AM.

132c Fire drill records *(continued)*

Plan of Correction ***Accept █ - 05/05/2023)***

Fire drills will be conducted monthly by Fire Fighter Sales and Service Co. beginning 5/10/23. The root cause of the violation was staff turnover and no maintenance director plus lack of documentation by previous staff. Staff was re-educated on fire drill procedures, which includes documentation on 4/28/23. Maintenance Director will be reviewing fire drill records monthly to ensure an unannounced fire drill is done monthly and documented in accordance with 2800.132c beginning 5/10/23.

Licensee's Proposed Overall Completion Date: *05/10/2023*

Not Implemented (LM - 07/06/2023)

132d Evacuation

27. Requirements

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

Description of Violation

On 7/14/21, the maximum evacuation time specified in writing by a fire safety expert was 3 minutes, 21 seconds. The residence exceeded the maximum evacuation time during the following fire drills:

- *5/26/22 at 11:00 AM-Evacuation time was 3 minutes, 27 seconds*
- *5/25/22 at 2:30 PM-Evacuation time was 4 minutes, 30 seconds*
- *5/24/22 at 10:00 AM-Evacuation time was 6 minutes, 18 seconds*

Plan of Correction ***Directed (█ - 05/05/2023)***

Fire drills will be conducted monthly by Fire Fighter Sales and Service Co. beginning 5/10/23 to include evacuation. Staff was re-educated on fire drill procedures and evacuation processes on 4/28/23. With the increase in residents, the fire expert will determine new evacuation times on 5/10/23. (DIRECTED: Documentation of the most recent maximum evacuation time specified by a fire safety expert shall be kept.█ 5/5/23). Maintenance Director will be reviewing fire drill records monthly to ensure an unannounced fire drill is done monthly and that all residents evacuate within the time specified beginning 5/10/23. The fire safety expert will determine maximum evacuation times based on current census. All drills will be done within this time frame or drills will be redone. Maintenance Director will be responsible to monitor compliance beginning 5/10/23.

Directed Completion Date: *05/11/2023*

Not Implemented █ - 07/06/2023)

132e Fire drill - sleeping hours

28. Requirements

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

Description of Violation

The residence has no documentation of a fire drill being held during sleeping hours since 6/29/21 at 5:35 AM.

132e Fire drill - sleeping hours *(continued)*

Plan of Correction ***Directed (█ - 05/05/2023)***

Fire drills will be conducted monthly by Fire Fighter Sales and Service Co. beginning 5/10/23 to include a fire drill during sleeping hours immediately. Staff was re-educated on fire drill procedures which includes ensuring a fire drill is held during sleeping hours at least once every 6 months on 4/28/23. Maintenance Director will be responsible to monitor compliance beginning 5/10/23. (DIRECTED: Beginning on 5/10/23: The maintenance director shall monitor all fire drill records monthly to ensure a fire drill is held during sleeping hours at least once every 6 months. █ 5/5/23).

DIRECTED: By 5/31/23: The residence shall conduct a fire drill during sleeping hours. Documentation of the fire drill shall be kept in accordance with 2800.132c. █ 5/5/23

Directed Completion Date: *05/31/2023*

Implemented (█ - 07/06/2023)

132f Alternate exit routes

29. Requirements

2800.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The residence used the same exit routes during the following 4 consecutive fire drills:

- *9/31/22 at 9:53 AM*
- *9/22/22 at 9:45 AM*
- *8/23/22 at 2:30 PM*
- *7/25/22 at 12:05 PM*

Plan of Correction ***Directed (█ - 05/05/2023)***

Alternate fire drill routes will be used during all future fire drills conducted monthly by Fire Fighter Sales and Service Co. beginning 5/10/23. Staff was re-educated on fire drill procedures which includes ensuring ensuring alternate exits are used on 4/28/23. Maintenance Director will be responsible to monitor compliance beginning 5/10/23. (DIRECTED: Beginning on 5/10/23: The maintenance director shall monitor all fire drill records monthly to ensure alternate exits are used during each fire drill. █ 5/5/23).

Directed Completion Date: *05/11/2023*

Not Implemented (█ - 07/06/2023)

132h Designated meeting place

30. Requirements

2800.
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

Not all residents were evacuated to a designated meeting place away from the building or within a fire-safe area

132h Designated meeting place (continued)

during the following drills:

- *9/31/22 at 9:53 AM-30 residents were present in the home; however, only 28 residents were evacuated*
- *9/22/22 at 9:45 AM-30 residents were present in the home; however, only 29 residents were evacuated*
- *5/26/22 at 11:00 AM-15 residents were present in the home; however, only 14 residents were evacuated*
- *5/25/22 at 2:30 PM-15 residents were present in the home; however, only 14 residents were evacuated*
- *5/24/22 at 10:00 AM-15 residents were present in the home; however, only 14 residents were evacuated*
- *4/7/22 at 1:45 PM-18 residents were present in the home; however, only 17 residents were evacuated*
- *3/18/22 at 3:45 PM-16 residents were present in the home; however, only 15 residents were evacuated*
- *2/28/22 at 8:16 AM-15 residents were present in the home; however, only 12 residents were evacuated*
- *1/14/22 at 2:06 PM-12 residents were present in the home; however, only 11 residents were evacuated*

Plan of Correction ***Accept █ - 05/05/2023)***

Fire drills will be conducted monthly by Fire Fighter Sales and Service Co. beginning 5/10/23 to include designated meeting places. Staff was re-educated on fire drill procedures which includes includes ensuring all residents evacuate during each drill on 4/28/23. Maintenance Director will be responsible for reviewing fire drill records monthly to ensure an unannounced fire drill is done monthly and that all residents evacuate during each drill beginning 5/10/23.

Licensee's Proposed Overall Completion Date: *05/10/2023*

Not Implemented █ - 07/06/2023)

141a Medical evaluation

31. Requirements

2800.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

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.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
12. Information about a resident's day-to-day assisted living service needs.

Description of Violation

Resident #1's medial evaluation, dated 12/27/22, does not include an immunization history or an indication resident #1 has had a tuberculin skin test administered with negative results within 2 years. These sections of resident #1's

141a Medical evaluation (continued)

medical evaluation are blank.

Resident #6's medical evaluation, dated 5/28/22, does not include a mobility needs assessment. This section of resident #6's medical evaluation is blank.

REPEAT VIOLATION: 1/11/2022, et. al.

Plan of Correction ***Accept (- 05/05/2023)***

Resident #1 and #6s medical evaluations were updated on 4/10/23 by ,LPN. All resident records will be reviewed for updated immunization administration by 5/31/23. A new admission checklist to ensure a medical evaluation completed in its entirety within 60 days prior to admission or within 30 days after admission for all new admissions was implemented on 5/1/23. All staff persons responsible for the completion of medical evaluations were re educated on the new checklist on 5/1/23. DON and ADM to monitor monthly beginning 6/1/23. Documentation of education will be kept in accordance with 2800.65L.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Not Implemented - 07/06/2023)

141b1 Annual medical evaluation

32. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #5's most recent medical evaluation was completed on 2/3/22.

REPEAT VIOLATION: 1/11/2022, et. al.

Plan of Correction ***Accept (- 05/05/2023)***

A new medical evaluation will be completed for resident #5 by 5/12/23. All resident records will be reviewed for updated immunization administration by 5/31/23. DON and ADM to monitor monthly for compliance beginning 6/1/23. All other resident records will be reviewed to ensure each resident has a completed medical evaluation at least annually and completed by 6/1/23. A monthly checklist was created on 4/27/23 to ensure timely completion of medical evaluations. Staff was educated on the tracking system for those staff for the completion of medical evaluations on 4/27/23. Documentation of education will be kept in accordance with 2800.65L.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Not Implemented - 07/06/2023)

162c Menus - posted

33. Requirements

2800.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

162c Menus - posted *(continued)*

Description of Violation

On 4/4/23, the only menu posted in the residence ended on 4/8/23. The following week's menu was not posted in a conspicuous and public place in the residence.

Plan of Correction ***Accept ██ - 05/05/2023)***

Two weeks of menus were posted on 4/8/23 in a conspicuous place. New Culinary Director will monitor on a weekly basis beginning on 5/2/23. New Culinary Director was educated on 5/1/23. Documentation of education will be kept in accordance with 2800.65L.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Not Implemented ██ - 07/06/2023)

183d Current medications

34. Requirements

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

Description of Violation

On 4/5/23, resident #8's bottle of Milk of Magnesia-400 mg/5ml, which was present in the medication cart, expired on 3/23/23.

REPEAT VIOLATION: 11/01/2022

Plan of Correction ***Accept ██ - 05/05/2023)***

Resident #8s bottle of milk of Magnesia was removed on 4/5/23. All med carts were inspected and debrided of expired medications on 4/14/2023. Education on current medication monitoring took place on 4/23 & 4/26. Documentation of education will be kept in accordance with 2800.65L. DON and ADM will be responsible for weekly audits for compliance beginning 4/26 and including expired medications, when meds were opened and dated, glucometer checks, all meds have diagnosis, missed emar documentation and accuracy, discontinued meds pulled and destroyed, all meds being available

.

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

Not Implemented (██ - 07/06/2023)

183e Storing Medications

35. Requirements

2800.
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 4/5/23, resident #5's Latanoprost-0.005% eye drops were open and undated. The pharmacy label for the eye

183e Storing Medications (continued)

drops indicate they were dispensed to the home on 2/19/23. According to the manufacturer's instructions, the eye drops must be discarded after 6 weeks of opening.

On 4/5/23, resident #8's Basaglar insulin flex pen was open and undated in the medication cart. According to the manufacturer's instructions, the insulin must be discarded 28 days after opening.

On 4/5/23, resident #8's Novolin R insulin pen was open and undated in the medication cart. According to the manufacturer's instructions, the insulin must be discarded 28 days after opening.

Plan of Correction ***Directed (- 05/05/2023)***

Resident #5's Latanoprost-0.005% eye drops resident #8's Basaglar insulin flex pen ,resident #8's Novolin R insulin pen were removed and replaced on 4/5/23 by DON and labeled with discarded date per manufactures instructions. All Carts have been audited on 4/6/23. Nursing staff will be reeducated on proper storage of medications, and checking expiry dates by 4/26-4/28. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2800.65L. 5/5/23). A list of meds will be kept with each cart to use to correctly mark these items. DON will audit compliance weekly for two months beginning 4/24/23 including expired medications, when meds were opened and dated, glucometer checks, all meds have diagnosis, missed emar documentation and accuracy, discontinued meds pulled and destroyed, all meds being available and then - (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. 5/5/23). DIRECTED: The monthly audits shall begin on 6/24/23. 5/5/23.

Directed Completion Date: *05/31/2023*

Not Implemented - 07/06/2023)

184a Resident meds labeled

36. Requirements

2800.

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

Resident #5 is prescribed Senna-8.6 mg tablet-Take 1 tablet by mouth as needed. Two medication cards are present in the residence; however, 1 of the pharmacy labels does not include the prescribed dosage.

REPEAT VIOLATION: 2/25/2022; 1/11/2022, et. al.

Plan of Correction ***Directed - 05/05/2023)***

Resident #5's medication cards were corrected to include prescribed dosage on 4/6/23. An audit was completed by RN on all pharmacy labels and corrections made by a Polaris Pharmacist on 4/14/23. Staff was educated on 4/26-4/28 as new meds are received to be checked for accuracy. New DON will audit compliance weekly beginning 4/24/23. (DIRECTED: During the weekly audits, the DON shall audit 50% of resident pharmacy labels. 5/5/23). Documentation of education will be kept in accordance with 2800.65L.

Directed Completion Date: *05/31/2023*

184a Resident meds labeled *(continued)*

Not Implemented ■ - 07/06/2023)

185a Storage procedures

37. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 4/5/23, resident #5's glucometer was not set to the current date.

Resident #8's April 2023 medication administration record (MAR) indicates resident #8's blood sugar was 273 on 4/4/23 at 4:00 PM; however, resident #8's glucometer indicates resident #8's blood sugar was 281 on this date and time.

Plan of Correction ***Accept ■ 05/05/2023)***

Resident #5's glucometer was set to current date on 4/5/23 by Polaris Pharmacy. Appropriate staff has been counseled on proper blood sugar documentation. All devices were checked for calibration and labeled specifically for each resident on 4/5/23. All appropriate staff was educated by DON for execution of blood sugars and documentation using appropriately calibrated equipment. on 4/26-4/28/23. Audits will be done checking for proper calibration, non sharing and appropriate documentation of results. DON will audit compliance weekly beginning 4/24/23. Audits for all residents prescribed blood sugar checks and insulin administration were completed on 4/6/23 Documentation of education will be kept in accordance with 2800.65L

Licensee's Proposed Overall Completion Date: *05/03/2023*

Not Implemented ■ - 07/06/2023)

186a Authorized prescriber

38. Requirements

2800.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

Resident #5 was prescribed Doxepin HCL-50 mg capsule-Take 1 capsule by mouth nightly. According to staff person H, The Director of Nursing, this medication was discontinued on 3/9/23; however, no copy of the discontinued order from the prescriber is present in the residence.

Plan of Correction ***Accept (■ - 05/05/2023)***

An order to D/C Doxepin was received and placed in resident #5's chart on 4/5/23. All charts will be checked for current prescription orders by DON and reeducation of appropriate nursing staff will occur by 4/29/23. DON will audit compliance weekly for two months beginning 4/29/23. And then monthly beginning 7/1/23. Documentation of education will be kept in accordance with 2800.65L.

186a Authorized prescriber *(continued)*

Licensee's Proposed Overall Completion Date: *05/03/2023*

Not Implemented ██ - 07/06/2023)

187a Medication record

39. Requirements

2800.
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 #1's April 2023 MAR does not include a diagnosis or purpose for Atorvastatin-10 mg tablet.

Resident #5 was prescribed Doxepin HCL-50 mg capsule-Take 1 capsule by mouth nightly. According to staff person H, The Director of Nursing, this medication was discontinued on 3/9/23; however, this medication is still present on resident #5's April 2023 MAR. Also, resident #5's April 2023 MAR indicates this medication was refused by resident #5 daily from 4/1/23 through 4/4/23.

Resident #5's April 2023 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- *Divalproex-250 mg tablet*
- *Doxepin HCL-50 mg capsule*
- *Jardiance-10 mg tablet*
- *Lisinopril-10 mg tablet*

Resident #7's April 2023 MAR does not include a diagnosis or purpose for numerous medications, to include the following:

- *Levothyroxine-112 mcg tablet*
- *Melatonin-3 mg tablet*
- *Oxycodone-5 mg tablet*

Plan of Correction ***Directed ██ 05/05/2023)***

Resident #5 Doxepin HCL-50 mg capsule was discontinued and removed from the cart and the mar on 4/5/23 by DON.

187a Medication record (continued)

Resident #5 and #7 MAR were updated by Pharmacy in conjunction with DON to include diagnosis or purpose on 4/5/23. All MARS were audited by 4/17/23 and updated for purpose of usage by DON. DON will audit compliance weekly beginning 4/29/23 to include expired or discontinued meds being removed from the cart and the mar with matching physician orders. All staff persons responsible for the completion of medical evaluations were re educated on the new checklist on 5/1/23. DON and ADM to monitor monthly beginning 6/1/23. Documentation of education will be kept in accordance with 2800.65L.

DIRECTED: By 5/15/23: All staff persons qualified to administer medications shall be re-educated on MAR requirements, which includes ensuring a diagnosis or purpose is present on resident MAR's for each prescribed medication. Documentation of the education shall be kept in accordance with 2800.65L. ██ 5/5/23).

Directed Completion Date: *06/01/2023*

Not Implemented ██ - 07/06/2023)

187d Follow prescriber's orders

40. Requirements

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

Description of Violation

Resident #1 is prescribed Atorvastatin-10 mg tablet-Take 1 tablet by mouth at bedtime; however, the medication was not administered to resident #1 nightly from 4/1/23 through 4/4/23.

Resident #5 was not administered the following medications, because they were not available in the residence for administration:

- *Latanoprost-0.005% eye drops-Instill 1 drop into both eyes at bedtime. This medication was not administered to resident #5 on 4/2/23, 4/3/23 and 4/4/23*
- *Vyzulta 0.024%-Instill 1 drop into both eyes at bedtime. This medication was not administered to resident #5 on 4/4/23*

Resident #7 was not administered the following medications, because they were not available in the residence for administration:

- *Melatonin-3 mg tablet-Take 1 tablet by mouth at bedtime. This medication was not administered to resident #7 nightly from 3/14/23 through 3/18/23*
- *Oxycodone-5 mg tablet-Take 1 tablet by mouth once daily. This medication was not administered to resident #7 on 3/5/23, 3/6/23, 3/7/23, 3/9/23 and 3/10/23.*

REPEAT VIOLATION: 11/01/2022, 1/11/2022, et. al.

187d Follow prescriber's orders *(continued)*

Plan of Correction ***Directed (- 05/05/2023)***

Resident #1 had resolution of the MAR immediately. Hope Hospice discontinued medication as life sustaining.
Resident #5 had medication adjustments made from an ocular appointment and new prescriptions were issued and sent to pharmacy and delivered on 4/5/23.
Resident #7 had been awaiting paper prescriptions for Oxycodone and was resolved 3/10/2023 and was emergency delivered from pharmacy.
DON will audit compliances in conjunction with med techs weekly to ensure any medications that are inspiring and will be reordered promptly. All staff persons responsible for the completion of medical evaluations were re educated on the new checklist on 5/1/23. DON and ADM to monitor monthly beginning 6/1/23. Documentation of education will be kept in accordance with 2800.65L.

DIRECTED: By 6/1/23: The Director of Nursing shall review all current resident medications, including the medications for residents #1, #5 and #7, to ensure all prescribed medications are present and available in the residence for administration in accordance with prescribed orders. 5/5/23

By 5/15/23: All staff persons qualified to administer medications shall be re-educated on the home's medication administration procedures, which includes ensuring medications are re-ordered prior to depleting the current supply. Documentation of the education shall be kept in accordance with 2800.65L. 5/5/23

DIRECTED: Beginning on 6/1/23: The Director of Nursing shall review all medications for at least 10 different residents weekly for 2 months then monthly thereafter to ensure all prescribed medications are present and available in the residence for administration in accordance with prescribed orders. Documentation of the audits shall be kept. LM 5/5/23

Directed Completion Date: *06/01/2023*

Not Implemented - 07/06/2023)

190a Completion of course–meds

41. Requirements

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

Description of Violation

Direct care staff person D completed the initial Department-approved medication administration course on 12/17/21; however, has not completed any annual practicums in accordance with the Department-approved medication administration course. Direct care staff person D has administered numerous medications to numerous residents, including resident # 7's Oxycodone-5mg tablet on 4/4/23 at 9:00 PM.

Direct care staff person E completed the initial Department-approved medication administration course on 12/26/21; however, has not completed any annual practicums in accordance with the Department-approved medication

190a Completion of course–meds (continued)

administration course. Direct care staff person E has administered numerous medications to numerous residents, including resident #1's Pantoprazole-40 mg tablet on 4/4/23 at 6:00 AM.

Direct care staff person F completed the initial Department-approved medication administration course on 3/27/22; however, has not completed any annual practicums in accordance with the Department-approved medication administration course. Direct care staff person F has administered numerous medications to numerous residents, including resident #5's Benztropine-1 mg tablet and Divalproex-250 mg tablet on 4/2/23 at 8:00 AM.

Direct care staff person G completed the initial Department-approved medication administration course on 5/4/21; however, has not completed any annual practicums in accordance with the Department-approved medication administration course. Direct care staff person G has administered numerous medications to numerous residents, including resident #5's Benztropine-1 mg tablet and Divalproex-250 mg tablet on 4/1/23 at 8:00 AM.

Plan of Correction ***Accept (- 05/05/2023)***

Med technician training for D,F, and G along with all other med techs and competency verification is occurring on 5/15/2023 through 5/30/2023. E has retired and is no longer employed at NH. All med tech training records were reviewed on 4/20/23 by DON. In addition, facility will schedule any recertification updates every six months to ensure compliance and competency to be monitored by DON and BOM beginning on 6/1/23. A tracking system for all med tech training will begin on 6/1/23 to be monitored by DON and BOM. Monthly reviews will begin on 6/1/23 by DON and BOM. The next QM meeting is 5/8/23.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Not Implemented - 07/06/2023)

191 Resident right to refuse

42. Requirements

2800.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1 has not been educated on their right to question or refuse medication if they believe there may be a medication error. Resident #1 was admitted to the residence on .

Resident #4 has not been educated on their right to question or refuse medication if they believe there may be a medication error. Resident #4 was admitted to the residence on

REPEAT VIOLATION: 1/11/2022, et. al.

Plan of Correction ***Directed - 05/05/2023)***

Resident #1 and resident #4 were educated on their right to refuse medication. on 4/7/23. All other resident records were audited on 4/27/23 by , LPN. Resident education will be done on each new admission to the facility and re education of all residents will occur at the next resident council meeting on 5/3/23. (DIRECTED: By 5/10/23: The administrator shall ensure documentation is present in each current resident's record ensuring they have been notified of their right to refuse or question a medication if they believe there to be an error. 5/5/23). This will be completed by the ADM. A new admission checklist was implemented on 5/1/23 and staff was educated the same day. Business office will be responsible for monitoring that all new admissions received resident rights information

191 Resident right to refuse (continued)

on admission. (DIRECTED: Beginning on 6/1/23: The business office shall review all new admission records monthly to ensure documentation is present in each new resident's record that they have been educated on their right to refuse or question a medication if they believe there to be an error. ██ 5/5/23). Documentation of education will be kept in accordance with 2800.65L

Directed Completion Date: *06/01/2023*

Not Implemented ██ - 07/06/2023)

224a2 30 days prior to admission

43. Requirements

2800.
224.a.2. An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

Description of Violation

Resident #7 was admitted to the residence on 1██; however, resident #7's initial assessment was not signed by the assessor until 1/6/23.

REPEAT VIOLATION: 1/11/2022, et. al.

Plan of Correction ***Directed ██ - 05/05/2023)***

Resident #7 initial assessment was signed on 4/6/2023. All initial assessment will be review for compliances prior to admission to the facility by the business office manager. (DIRECTED: The business office reviews for the completion of new resident assessments shall begin on 5/10/23 and shall be completed on the day of admission for each newly-admitted resident. ██ 5/5/23). A new admission checklist was implemented on 5/1/23 and staff was educated the same day. Business office will be responsible for monitoring that checklist is completed on admission. Documentation of education will be kept in accordance with 2800.65L

DIRECTED: By 6/1/23: The administrator shall review all current resident records to ensure each resident has an assessment completed in its entirety. ██ 5/5/23

Directed Completion Date: *06/01/2023*

Not Implemented ██ - 07/06/2023)

225a1 Assessment – annually

44. Requirements

2800.
225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident #5's most recent assessment was completed on 2/10/22.

REPEAT VIOLATION: 1/11/2022, et. al.

225a1 Assessment – annually *(continued)*

Plan of Correction ***Directed - 05/05/2023)***

: (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. 5/5/23) DIRECTED: By 5/10/23: The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete a new assessment for resident #5. A copy of resident #5's new assessment shall be kept in resident #5's record. 5/5/23). All other resident records were reviewed by , LPN and J QA nurse on 4/26 & 4/27. A new tracking system to ensure timely completion of annual assessments, was completed on 4/27 by ,LPN. DON and ADM will be responsible for the monthly reviews beginning 6/1/23. Staff was educated on the tracking system for the completion of resident assessments on 5/1/23. DON will continue to monitor ongoing compliance weekly and update assessments as needed. Documentation of education will be kept in accordance with 2800.65L.

Directed Completion Date: *06/01/2023*

Not Implemented (- 07/06/2023)

227c Final support plan - revision

45. Requirements

2800.
227.c. The final 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. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

The most recent quarterly review of resident #5's support plan was completed on 8/8/22.

The most recent quarterly review of resident #6's support plan was completed on 3/13/23; however, the previous quarterly review was completed on 9/19/22.

REPEAT VIOLATION: 1/11/2022, et. al.

Plan of Correction ***Directed - 05/05/2023)***

(UNACCEPTABLE PORTION OF PLAN OF CORRECTION. 5/5/23) DIRECTED: By 5/10/23: The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete a new support plan for resident #5. A copy of resident #5's new support plan shall be kept in resident #5's record. 5/5/23). The root cause was the DON terminated employment and new DON did not start until 2/23. New DON and ADM will review all resident support plans weekly beginning on 4/24/23. Initial and final support plan scheduling will be set 30 days on arrival and quarterly there after to be monitored by the DON or ADM beginning on 5/1/23. A tracking system was implemented on 4/27/23 by DON and staff was educated on the same day. Documentation of education will be kept in accordance with 2800.65L.

Directed Completion Date: *05/10/2023*

Not Implemented - 07/06/2023)

227h Support plan – refusal sign

46. Requirements

2800.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1's most recent support plan, dated 1/9/23, is not signed by resident #1 and does not indicate if resident #1 was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction ***Accept (- 05/05/2023)***

Resident #1 was re approached with support plan and this was signed on 4/5/2023. All other support plans by QA nurse and ,LPN. were reviewed on 4/26 and 4/27. Documentation of acceptance of care will be done on admission and with any significate changes. There will be documentation to reasons on refusals to sign. A tracking system was implemented on 4/27/23 by DON and staff was educated on the same day. Documentation of education will be kept in accordance with 2800.65L. DON will monitor monthly or compliance beginning 6/1/23.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Not Implemented - 07/06/2023)

231c1 Preadmit screening

47. Requirements

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

Description of Violation

Resident #1 was admitted to the SCU on ; however, resident #1's cognitive preadmission screening is undated, so it is unable to be determined if it was completed within 72 hours prior to admission to the SCU.

REPEAT VIOLATION: 1/6/2023; 1/11/2022, et. al.

Plan of Correction ***Directed - 05/05/2023)***

Resident #1 cognitive preadmission screening was signed on 4/6/23 by LPN. Hospice services were also initiated for this resident. All other resident records were reviewed on 4/6/23 by ,LPN. On admission to SCU cognitive preadmission screening will be done by DON or designee (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. Cognitive preadmission screenings for all residents admitted to the residence's SCU shall be completed within 72 hours prior to admission. 5/5/23). DON will ensure dating on each form. A new admission checklist to ensure a cognitive preadmission screening is completed (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. Cognitive preadmission screenings for all residents admitted to the residence's SCU shall be completed within 72 hours prior to admission. 5/5/23) for all new admissions was implemented on 5/1/23. Staff members were educated on the checklist 5/1/23. Monitoring will occur weekly by ADM beginning 5/8/23. Documentation of education will be kept in accordance with 2800.65L.

DIRECTED: By 5/10/23: All staff persons involved in the admission process shall be educated on the new admission checklist, as well as regulation 2800.231c(1) to ensure a written cognitive preadmission screening is completed within 72 hours prior to admission for all new residents admitted to the residence's SCU. Documentation of the education shall be kept in accordance with 2800.65L. 5/5/23).

231c1 Preadmit screening *(continued)*

Directed Completion Date: *05/10/2023*

Not Implemented [redacted] - 07/06/2023)

231d No objection statement

48. Requirements

2800.
231.d. Resident admission to special care unit. Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident’s designated person or the resident’s family have agreed to the resident’s admission or transfer to the special care unit.

Description of Violation

Resident #1 was admitted to the SCU on [redacted]; however, resident #1's record does not include documentation resident #1 has agreed to the admission to the SCU.

REPEAT VIOLATION: 1/06/2023

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

Resident #1 cognitive preadmission screening was done and signed on 4/6/23. Hospice services were also initiated for this resident. All other resident records were reviewed to ensure all current residents in the SCU signed the documentation agreeing to the admission on 4/6/23 by [redacted], LPN. A new admission checklist to ensure documentation is obtained at admission that they agree to the admission to the SCU for all newly-admitted residents on 5/1/23. Staff members were educated on the checklist 5/1/23. On admission to SCU cognitive preadmission screening will be done by DON or ADM. DON will ensure dating on each form. Documentation of education will be kept in accordance with 2800.65L.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Not Implemented [redacted] - 07/06/2023)