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

July 10, 2023

[redacted], OWNER/OPERATOR
DELAWARE VALLEY PERSONAL CARE OPERATING COMPANY LLC
[redacted]

RE: DELAWARE VALLEY PERSONAL CARE CENTER
109 RIVERS EDGE DRIVE
MATAMORES, PA, 18336
LICENSE/COC#: 23013

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/27/2023, 05/02/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *DELAWARE VALLEY PERSONAL CARE CENTER* **License #**: *23013* **License Expiration**: *04/26/2024*

Address: *109 RIVERS EDGE DRIVE, MATAMORES, PA 18336*

County: *PIKE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *DELAWARE VALLEY PERSONAL CARE OPERATING COMPANY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *03/03/2021* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/02/2023*

Inspection Dates and Department Representative

04/27/2023 - On-Site: [redacted]

05/02/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *49*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *49*

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

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

04/27/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/29/2023*

06/07/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/14/2023*

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

Inspections / Reviews *(continued)*

06/14/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/14/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/24/2023*

07/10/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/14/2023*

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

17 - Record Confidentiality

1. 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 5/2/23, while doing a physical site inspection, the Medication Administration record book, that contained all second-floor residents personal medication information, and the narcotic logbook was observed on the top of the cart, unattended.

Plan of Correction ***Accept [redacted] - 06/07/2023)***

-On 5/2 verbal education on Regulation 17. was immediately provided to the medication technician assigned to unit by Administrator.
- Audits will be conducted by Administrator/Wellness Director at random, weekly x 4 weeks to ensure confidentiality of resident records to begin week of 5/7/23 and completed by 6/9/2023.
-All current staff will be educated on regulation 17. by 6/9/2023
-Moving forward resident records will be maintained in a secured area.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented ([redacted] - 07/10/2023)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted], for resident #1 was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 06/07/2023)***

-On [redacted] Resident #1 refused signing contacted and had preference for the responsible party to sign. Administrator should have documented residents refusal to sign.
-Audit of all Resident contracts will be conducted by Administrator to ensure contract signatures. If there are findings of missing signatures Administrator will re-review with residents and document accordingly.
-All current staff will be educated on Regulation 25.5 by 6/9/23.
-Administrator will ensure appropriate contract signatures are obtained immediately upon admission of any new residents if resident agrees.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented ([redacted] - 07/10/2023)

26b - Quality Management Plan Content

3. Requirements

2600.

26b - Quality Management Plan Content *(continued)*

26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management review dated [redacted] did not address complaint procedures or resident counsel meetings.

Plan of Correction ***Accept [redacted] - 06/14/2023)***

-On 5/3/23 a meeting was held with QA members to address complaint procedures and resident council meetings.
-All current staff will be educated on Reg. 26.b by 6/9/23
-A checklist was created to be reviewed at all Quality Management Plan meetings to ensure all required areas are reviewed moving forward.
-Administrator will be responsible to ensure ongoing compliance to ensure all required topics are addressed at every QA meeting moving forward.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented ([redacted] - 07/10/2023)

57d - Waking Hours

4. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

The homes current census is 49, with 5 immobile residents. The home has three shifts. First shift is 7:00a -3:30p, second shift is 3:00p – 11:30p, and third shift is 11:00p to 7:30a. . On [redacted], home needed 40.5 staffing hours during waking hours. However, home only had 37.125 hours.

Plan of Correction ***Accept ([redacted] - 06/07/2023)***

-On 5/2/23 Administrator re-reviewed the schedule provided to inspector and compared with hours on the time-clock website and found that direct care staff hours on schedule were not recorded properly.
-A print out of hours from 4/6/23 will be provided to the department to validate that there was the appropriate amount of waking hours provided to residents on 4/6/23.

-All current staff will be educated on Reg. 57d by 6/9/23.

-Administrator will create a new form to be utilized to ensure that actual direct care staff hours are recorded and form will be reviewed weekly and also reviewed at QA meetings.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented ([redacted] - 07/10/2023)

60a - Staff/Support Plan

5. Requirements

2600.

60a - Staff/Support Plan *(continued)*

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

The home currently serves 49 residents, 5 of these residents need assistance to evacuate during an emergency. On [redacted] 1 staff persons were scheduled from 8:30p to 11:00p. In the event of an emergency the home does not have enough staff to meet the needs of the residents.

Plan of Correction ***Accept ([redacted] - 06/07/2023)***

-On 5/2/23 Administrator re-reviewed the schedule provided to inspector and compared with hours on the time-clock website and found that direct care staff hours on schedule were not recorded properly.
-A print out of hours from 4/6/23 will be provided to the department to validate that there was the appropriate amount of staff scheduled provided to residents on 4/6/23.
-All staff will be educated on Reg. 60a by Administrator by 6/9/23.
-Administrator/ Wellness Director will always ensure that the appropriate amount of staff will be scheduled to support the needs of the residents.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented ([redacted] - 07/10/2023)

85d - Trash Receptacles

6. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

A trash can located in the kitchen was uncovered.

Plan of Correction ***Accept [redacted] - 06/07/2023)***

- on 5\2\23 administrator provided verbal education to employees in Kitchen on duty to have lids on trash cans at all times.
- random audit will be conducted weekly x 4 weeks to ensure that trash cans and kitchen have lids on as required.
- all current staff will be educated by the administrator on Reg85d by June 9th 2023
- kitchen manager and kitchen staff will continue on going compliance with requirements of trash receptacles in kitchen

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented ([redacted] - 07/10/2023)

89b - Hot Water Temperature

7. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

The water temperature of the first-floor bathroom, located by the activities room, was 132.6 degrees and the water temperature in the Hall B bathroom was 129.1 degrees.

89b - Hot Water Temperature *(continued)*

Plan of Correction ***Accept (- 06/14/2023)***

-On 5\2\23 maintenance employee notified of hot water temp that exceeded 120°f, maintenance employee immediately adjusted temperature to regulation temperature and it was monitored times 4 hours on 5/23 at regulated temperature.

- daily audit conducted to ensure proper temperature for hot water initiated 5/3/23 daily for one week, then one time a week for 4 weeks.

- all current staff will be educated on regulation 89b by administrator by 6\9\23

- monthly maintenance checklist has been updated to review temperature checks at random areas of facility to ensure temp does not exceed 120° f

-Maintenance Director and Administrator will continue to ensure ongoing compliance with hot water temperature.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented - 07/10/2023)

91 - Telephone Numbers

8. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The telephone numbers required by this regulation were not posted by the phones located in room # 110.

Plan of Correction ***Accept - 06/07/2023)***

-On 5\2\23 emergency telephone numbers were reposted by telephone in room number 110.

- Audit conducted by administrator on 5/3/23 to ensure all areas that have outside lines will have emergency telephone numbers posted on or by each telephone.

- all staff will be educated on regulation 91 by June9th2023.

- administrative will complete monthly room audits to ensure emergency numbers are located on or near outside lines in all areas.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented (- 07/10/2023)

103g - Storing Food

9. Requirements

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

Description of Violation

The refrigerator located in the main kitchen had 1 squeeze whip cream and a container of bologna luncheon meat that was not in a seal container.

Plan of Correction ***Accept (- 06/07/2023)***

- on 5\2\23 administrator provided verbal education to Kitchen staff on duty about proper storage of food items. Food items found during review were immediately discarded in the trash.

- audit will be conducted by administrator and kitchen manager at random weekly starting the week of 5/7/2023

103g - Storing Food (continued)

x4 weeks.

- all current kitchen staff will be educated on regulation 103 G by June 9th 2023

- kitchen manager will continue to review proper food storage with kitchen employees and do daily/ weekly checks of areas containing stored food

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented ([redacted] - 07/10/2023)

103i - Outdated Food

10. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

The freezer located in the main kitchen had 4 bags of corn, a bag of squeeze whip cream, and a cream pie that were not labeled with a date.

Plan of Correction ***Accept ([redacted] - 06/07/2023)***

-On 5\2\23 administrator provided verbal education to Kitchen staff on duty to ensure if anything that doesn't contain an expiration date on item taken out of container/box that the expiration be immediately recorded on item.

- kitchen manager will do audits weekly x4 weeks to ensure all items have been dated beginning week of 5\7\23 and completed by 6\9\23

- all kitchen staff will be educated on regulation 103i by 6\9\23.

- kitchen manager and all kitchen staff will continue to ensure all items are dated.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented ([redacted] - 07/10/2023)

105c - Supply Linens/Towels

11. Requirements

2600.
105.c. The supply of bed linens and towels shall be sufficient to ensure a complete change of bed linen and towels at least once per week.

Description of Violation

Home currently has 49 residents. There were 19 sets of clean linens in the clean linen storage closet on 5/2/23.

Plan of Correction ***Accept ([redacted] - 06/14/2023)***

-On 5\2\23 administrator pulled linens out of outside storage to ensure that an adequate supply of linens are accessible.

-an extra supply of linens will be purchased by facility from direct supply by 6\9\23.

- all current staff will be educated on regulation 105c by administrator by June 9th 2023

- a monthly inventory will be conducted for continued supply of Linens by housekeeping staff and reported to administrator.

-Administrator will monitor linen inventory to ensure ongoing compliance with adequate supply of linens for facility.

Licensee's Proposed Overall Completion Date: *06/12/2023*

105c - Supply Linens/Towels *(continued)*

Implemented [redacted] - 07/10/2023)

121a - Unobstructed Egress

12. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 5/2/23, at 9:00am, a stack of chairs was observed sitting in front of the emergency exit door in the Activities room.

Plan of Correction ***Accept ([redacted] - 06/07/2023)***

- on 5\2\23 administrator immediately remove stacked chairs from in front of emergency exit door in activities room and also provided verbal education to activities staff immediately on unobstructed egresses.
- audit will be conducted at random a few times weekly for 4 weeks by administrator to ensure that there are unobstructed egresses.
- all staff will be educated on regulation 121a by June 9th 2023.
- all staff members will continue ongoing observation to ensure their is unobstructed egresses at all times.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented [redacted] - 07/10/2023)

125a - Combustible Storage

13. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

Department Representative observed a dryer sheet and a hand towel behind the dryer, laying on the vent hose, in the 1st floor laundry room.

Plan of Correction ***Accept ([redacted] - 06/07/2023)***

-On 5\2\23 administrator immediately remove dryer sheet and hand towel from behind dryer and verbally educated staff on duty to ensure if items are dropped in that area that they be immediately removed.
- an audit will be conducted at random two times a week for 4 weeks beginning the week of 5/7/23 by administrator.
- all staff will be educated on regulation 125a by 6/9/23.
All staff will continue to ensure if items are dropped behind machines that they will be removed immediately.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented ([redacted] 07/10/2023)

132f - Alternate Exit Routes

14. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

132f Alternate Exit Routes *(continued)*

Description of Violation

The home conducted 7 fire drills between 9/29/22 and 3/31/23. Of those drills, all 7 drills that were conducted by using the home's A & B stairs to exit for the evacuation.

Plan of Correction ***Accept (- 06/07/2023)***

On 5\2\23 administrator met with maintenance director who conducts fire drills and educated to use alternate exit routes.

administrator was present at next unannounced fire drill to ensure alternate routes were utilized.

all staff will be educated on regulation 132f by 6/9/23

fire drills will be reviewed at quality meetings to ensure alternate exit routes have been utilized during fire drills.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented (- 07/10/2023)

141a 1-10 Medical Evaluation Information

15. 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. 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 #2's medical evaluation was completed on No information was listed for the resident's weight.

Plan of Correction ***Accept - 06/14/2023)***

Resident #2's weight was unobtainable during medical evaluation and should have been documented as such.

An audit will be conducted to ensure that each section of the medical evaluation information form has been documented by by Administrator\wellness director. If there are findings of undocumented areas administrator/wellness director will review with residents physician and area will ne addressed.

All current staff will be educated on regulation141.a by

Administrator and Wellness Director will monitor the DME's regularly to ensure ongoing compliance moving forward.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented (- 07/10/2023)

162c - Menus Posted

16. Requirements

162c - Menus Posted *(continued)*

2600.
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.

Description of Violation

The menus posted did not match what was being served. The home reported that the menus were changed on 5/1/23 from the Fall/Winter menu to the Spring Summer menu.

Plan of Correction ***Accept (- 06/14/2023)***

-On 5\2\23 administrative assistant and kitchen manager were verbally educated on 162c by administrator. Current menus were posted immediately.
- all staff will be educated on regulation 162c by 6/9/23.
- menu postings will be reviewed at quality meetings moving forward.
-Administrator will monitor for ongoing compliance moving forward to ensure the right menu posting are up.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented (- 07/10/2023)

183f - Discontinued Medications

17. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

Located in the medication cart was a bottle of [redacted] that belonged to Resident # 9. Staff A verified that those are discontinued medications.

Plan of Correction ***Accept (- 06/07/2023)***

-On 5\2\23 administrator and wellness director did an audit of medication storage cards to ensure discontinued meds were disposed of.
- all it will be conducted weekly times 4 weeks to ensure there are no discontinued medications in storage carts.
- all medication technicians will be educated on regulation 183.a by administrator and wellness director by 6/9/23.
- Wellness director will continue to audit medication carts monthly.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented (- 07/10/2023)

184a - Resident's Meds Labeled

18. Requirements

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

184a Resident's Meds Labeled *(continued)*

Description of Violation

Resident #9 Medication Administration Record indicated that resident #9 takes [redacted] once a day. However, the pill pack states [redacted] once a day. Residents order changed on 4/13/23 from [redacted] once per day. Conversation with staff A indicated that resident was being given ½ a pill and the other half was being discarded.

Plan of Correction ***Accept [redacted] - 06/14/2023)***

On 5\2\23 the container of resident #9's label was labeled with an alert "order change" sticker.

An Audit will be conducted by Wellness director to ensure if there were any prescribed dosage changes or instructions that they be labeled accordingly by6/9/23.

all medication technicians will be educated by Wellness director by 6/9/23

all staff personnel that do medication administration will continue to maintain compliance with medications as ordered to be labeled as such.

Administrator and Wellness Director will continue to monitor medication labels for ongoing compliance moving forward.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented ([redacted] - 07/10/2023)

184b - Labeling OTC/CAM

19. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [redacted], a bottle of [redacted] belonging to resident 7, bottle of [redacted], [redacted], and [redacted] belonging to Resident 9, [redacted] and [redacted] belonging to Resident 10, bottle [redacted] belonging to Resident 11, box of [redacted] belonging to Resident #12 and [redacted], and [redacted] belonging to Resident 13 was in the 2nd floor Med Cart and was not labeled with the resident's name. Staff A confirmed who each of the medications belonged to.

Plan of Correction ***Accept [redacted] - 06/07/2023)***

On 5\2\23 all over the counter medications unlabeled that were identified were labeled with residents name by Wellness director.

an audit will be conducted weekly times 4 weeks by Wellness director to ensure that all OTC bottles are labeled with residents name.

all medication technicians will be educated by Wellness director on the labeling of all otcs by 6/9/23

All OTC medications belonging to the resident will be identified with the residents name.

Licensee's Proposed Overall Completion Date: *06/09/2023*

Implemented [redacted] - 07/10/2023)

185a - Implement Storage Procedures

20. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #3's glucometer was not calibrated to the correct time and Resident #4"s glucometer was not calibrated to the correct time and date. The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident #4 – At [redacted] on [redacted] the reading on the glucometer was [redacted] but was incorrectly transcribed as [redacted]. Resident #8 is prescribed [redacted]. During medication cart review on 5/2/23, this medication was not available. The home narcotic policy indicates that the home oncoming/off going medtechs will count narcotics to ensure accuracy. On [redacted] at [redacted] and [redacted] at [redacted] and [redacted] Staff B did not sign that Staff B participated in narcotic counts per homes narcotic policy.

Plan of Correction ***Accept ([redacted] - 06/14/2023)***

-On 5/3/23 resident #3 and #4 glucometer was calibrated to the correct time immediately by the wellness director. The staff member that recorded incorrect documentation of blood sugar for resident # 4 was educated on importance to record as identified by the wellness director verbally. On 5/2/23 Wellness Director notified physician of resident #8 on the missing dose of Polyeth Glycol and it was ordered from the pharmacy immediately. All staff participating in narcotic count were verbally educated by Wellness Director/Administrator via phone and in person to ensure the accuracy of the narcotics upon and departure of shift with incoming/outgoing staff.
-An audit will be conducted on residents that receive glucometer readings weekly x 4 weeks by Wellness director to ensure proper documentation and calibrated glucometers beginning 5/7/23 and will be completed by 6/9/2023. then ongoing.
-An audit of prescribed orders will be conducted by wellness director to ensure medications are at the facility and will be completed by 6/9/23.
-An random audit will be conducted weekly x 4 weeks to ensure the oncoming/off going Medtechs will count narcotics to ensure accuracy beginning 5/7/23 and will be completed by 6/9/23.
-All staff will be educated on regulation 185a by Wellness Director/Administrator by 6/9/23.
-Administrator and Wellness Director will continue ongoing compliance with safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented ([redacted] - 07/10/2023)

187a - Medication Record

21. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

On 5/1/23, the home transitioned to a new electronic Medication Administration record. All of Resident # 14 medications did not transfer appropriately. Therefore, on [redacted], resident #14 did not receive [redacted] at bedtime and [redacted] at bedtime as prescribed.

Plan of Correction ***Accept ([redacted] - 06/14/2023)***

-On 5/2/23 Wellness director informed resident #14 and responsible party of missed medications and also immediately informed pcp.
-on 5/3/23 Administrator/Wellness Director reviewed all resident medication orders to emar system to ensure all

187a Medication Record (continued)

medications were assigned as ordered.
All staff will be educated on Regulation 187a by Wellness Director/ Administrator by 6/9/23.
Medication records will be maintained as ordered from prescriber.
Administrator and Wellness Director will monitor medication records for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented (- 07/10/2023)

187b - Date/Time of Medication Admin.

22. 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

Medication administration record for Resident #8 indicates that on [redacted] are all not due. However, all of these medications are straight orders. Upon speaking to staff, these medications were given but the new system documented the MAR incorrectly.

Plan of Correction ***Accept (- 06/14/2023)***

On 5/3/23 Emar system was identified to have not pulled all orders adequately and Wellness Director reviewed resident # 8's orders and reassigned them to document correctly on MAR report.
A audit will be conducted of Resident MARS to ensure all medications are able to show on MAR report instead of under "other" orders by Wellness Director and will be completed by 6/9/23.
Administrator will educate Wellness Director on Reg 187d by 6/9/2023.
All medication's date/time shall show medication times on report.
Administrator and Wellness Director will continue to monitor to maintain compliance.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented - 07/10/2023)

187d - Follow Prescriber's Orders

23. Requirements

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

Description of Violation

On [redacted] Resident #3 is on a sliding scale. For readings between 200 250 2u, 251 300 4u, 301 350 6u, 351 400 8u, 401 500 10u. On [redacted] Resident #3's blood glucose reading was [redacted]. Resident #3 was administered [redacted] units of insulin instead of [redacted] and on [redacted], Resident #3's blood glucose reading was [redacted]. Resident #3 was administered [redacted] of insulin instead of [redacted].

On [redacted], resident #14 did not receive [redacted] at bedtime and [redacted] at bedtime as prescribed.

187d - Follow Prescriber's Orders (continued)

Repeat Violation 2/15/22

Plan of Correction ***Accept (- 06/14/2023)***

-On 5/2/23 resident and responsible parties if indicated were notified by the Wellness Director for findings that were not administered as prescribed. The Wellness Director also notified PCP. for each identified resident. Wellness Director also verbally educated staff that administered/did not administer medications as prescribed.
-Audits of prescriber's orders will be reviewed weekly x 4 weeks by Wellness Director and will be completed by 6/9/23.
-All medication administrators will be educated on regulation 187d by 6/9/23.
-All medication administrators will maintain following prescriber's orders.
-Administrator and Wellness Director will review often to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented - 07/10/2023)

227d - Support Plan Medical/Dental

24. 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

The Assessment and support plan dated for Resident #5,1 for Resident #7, and for Resident # 2, does not indicate that the residents utilize bed enablers.

Plan of Correction ***Accept (- 06/14/2023)***

-On 5/2/23 Wellness director immediately documented the usage of enabler bars in the support plan and reviewed with each resident indicated.
-An audit will be conducted by Administrator/ Wellness Director of all residents utilizing enablers bars that are documented in support plans by 6/9/23.
-All staff will be educated on reg 227s by 6/9/23.
-Administrator and Wellness Director will continue to monitor for ongoing compliance.
- Wellness Director will continue to document the usuage of enabler bars in support plan.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented - 07/10/2023)

227g -Support Plan Signatures

25. Requirements

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

227g Support Plan Signatures *(continued)*

Description of Violation

Resident #5 participated in the development of his/her support plan on [redacted] and Resident #6 participated in the development of his/her support plan on [redacted] However, the residents did not sign their support plan.

Plan of Correction ***Accept ([redacted] - 06/14/2023)***

on 5/4/23 wellness director reviewed support plans with indicated residents and signatures were obtained.

an audit will be conducted of residents support plans by Administrator/ Wellness Director to ensure signatures are obtained on support plans. If during audit there are missing signatures identified Administrator/Wellness Director will review support plans with identified residents and obtain signatures.

all staff will be educated by Administrator/ wellness director of reg. 227g by 6/9/2023.

Administrator and Wellness Director will continue to ensure ongoing compliance with monitoring support plans.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented [redacted] - 07/10/2023)