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

June 22, 2023

NELSON GOLDEN YEARS, INC.

RE: NELSON'S GOLDEN YEARS
137 OKLAHOMA CEMETERY ROAD
DUBOIS, PA, 15801
LICENSE/COC#: 44868

Dear Ms. Jackie Syktich,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/02/2023, 05/03/2023 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *NELSON'S GOLDEN YEARS* **Licen e #**: *44868* **Licen e Expiration**: *08/25/2023*

Address: *137 OKLAHOMA CEMETERY ROAD, DUBOIS, PA 15801*

County: *CLEARFIELD* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *NELSON GOLDEN YEARS, INC.*

Address

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *11/05/1993* **I ued By**: *L&L*

Type: *I 2* **Date**: *07/08/2011* **I ued By**: *Bureau Veritas NA*

Type: *Other* **Date**: *06/29/2011* **I ued By**: *Bureau Veritas NA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/03/2023*

Inspection Dates and Department Representative

05/02/2023 On Site

05/03/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *50*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *50*

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

Have Mobility Need: *6* **Have Physical Disability**: *0*

Inspections / Reviews

05/02/2023 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/21/2023*

Inspections / Reviews *(continued)*

05/26/2023 - POC Submission

Submitted By [redacted] **Date Submitted**: *06/16/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/31/2023*

06/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/16/2023*

Reviewer [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/16/2023*

06/22/2023 - Document Submission

Submitted By [redacted] **Date Submitted**: *06/16/2023*

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

3c - Post Current License

1. Requirements

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

Description of Violation

On 5/2/23 and 5/3/23 the home's licensing inspection summaries, dated 6/14/22 and 2/14/23, were posted in a locked bulletin board in the front hallway of the home.

Plan of Correction ***Accept (- 06/02/2023)***

1. Why is this regulation important?
Residents need to be able to access materials such as the licensing inspection summaries.

2. How was the regulation violated?
The Bulletin Board is locked;; therefore, residents would not have free access to the licensing inspection summaries.

3. What caused the violation?
We put in an Encased Bulletin Board, which is a locked bulletin board.

4. What can be done right away to fix the violation?
We moved the licensing inspection summaries to the bulletin board across from this one, so that residents can freely access the materials. (Upload: Photo of Bulletin Board.)

5. What can we do to prevent future violations?
When posting Resident materials or information for their use, we will post on the open bulletin board.

6. Who will be responsible for preventing future violations?
The Home Administrators are responsible for maintaining the material posted on our bulletin boards. Administration has meetings weekly. When the ombudsman comes in our building, we always meet with them and we review the contents of our bulletin board. We have already met with our ombudsman and made them aware of the locked bulletin board and that we will utilize the open bulletin board. The ombudsman did attend the exit meeting with our Licensing Inspector.

UPDATE JDS 5/29/2023: Paperwork was removed from Locked Bulletin Board Cabinet on 5/18/23 and displayed on Open Bulletin Board. Administrator will continue to use unlocked bulletin board to display items for resident review. tems put on bulletin board will be reviewed monthly by the Administrator along with Med Director and Administrative Assistant.

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented (- 06/22/2023)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

18 - Compliance With Laws *(continued)*

Description of Violation

The Care Facility Carbon Monoxide Alarms Standard Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. If there are resident living units or bedrooms located between a fossil fuel burning appliance and any additional approved carbon monoxide alarm required under paragraph (2), a single additional approved carbon monoxide alarm shall be installed in a central location on the same level as the resident living units or bedrooms.
On 5/2/23, the closest carbon monoxide alarm was approximately 20 feet from the gas dryer in the "green bathroom" in the front hallway. However, there are three bedrooms located between the carbon monoxide alarm and the gas dryer.

Plan of Correction ***Accept (- 06/02/2023)***

1. Why is this regulation important?
To maintain safety of residents and staff.

2. How was the regulation violated?
Carbon Monoxide Alarm was more than 15 feet away from gas dryer in the "green bathroom" in the front hallway. There are three bedrooms located between the carbon monoxide alarm and the gas dryer.

3. What caused the violation?
Administration were not aware that the carbon monoxide detector was not close enough to the "green bathroom" in the front hallway.

4. What can be done right away to fix the violation?
mmediately on 5/2/2023, the Home Administrator met with the Maintenance Director and he put a new carbon monoxide alarm right outside the door of the "green bathroom" in the front hallway. The other carbon monoxide alarm which was over 15 feet away from this bathroom was left intact, too. (Upload: Photo of Carbon Monoxide Alarm area.)

5. What can we do to prevent future violations?
Administration and maintenance reviewed the building for carbon monoxide detectors and their distance to appliances.

6. Who will be responsible for preventing future violations?
Maintenance Director will be responsiible to check this. .

UPDATE JDS 5/29/2023: The Maintenance Director does monthly checks of the fire extinguishers. In meeting with our Building Inspection Team, Certa-Site, we added the carbon monoxide detectors to this list to be checked monthly.

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented (- 06/22/2023)

66b - Training Plan Content

3. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

On 5/3/23, the home's 2023 staff training plan did not include:

** The name, position and duties of each direct care staff person.*

** The required training courses for each staff person.*

** The times and locations of the scheduled training for each staff person*

Plan of Correction ***Accept (- 06/02/2023)***

1. Why is this regulation important?
To ensure that staff keep current with health-related educational topics that allow knowledge to benefit residents' care.

2. How was the regulation violated?
Some content was missing from current Staff Training Plan.

3. What caused the violation?
We did not realize we were missing some content that made us non-compliant.

4. What can be done right away to fix the violation?
We updated the current Staff Training Plan immediately. (Upload the Staff Training Plan content page that had missing information.)

5. What can we do to prevent future violations?
Administrators will continue to be educated at conferences, on-line classes, and take College classes to review this.

6. Who will be responsible for preventing future violations?
Personal Care Home Administrators are responsible for the Staff Training Plan.

UPDATE 5/29/2023: is an Administrator at the HOME and is responsible for the Staff Training Plan. has updated the Staff Training Plan after meeting with the Inspector and reviewing the contents of our Plan. added the section that was discussed. This is the section we added to be in compliance: "All the required training is provided by Nelson's Golden Years, manages the training and is supervised by Administrator, All employees are required to attend. The location of the training is Nelson's Golden Years and all staff receive 1 credit for each month totaliing 12 credits for the year. " (See Upload.)

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented (06/22/2023)

132d - Evacuation

4. Requirements

2600.
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 home.

Description of Violation

The home has a maximum safe evacuation time of 5 minutes and 40 seconds specified in writing within the past year by a fire safety expert. The home exceeded the evacuation time of 5 minutes and 40 seconds during the following drills:

** 10/31/22, at 10:05 pm., evacuated in 6 minutes and 57 seconds*
** 2/27/23, at 6:13 pm., evacuated in 7 minutes and 31 seconds*
** 4/30/23, at 11:00 pm., evacuated in 8 minutes and 30 seconds*

Plan of Correction ***Accept (- 05/26/2023)***

1. Why is this regulation important?
To provide a safe and effective timeframe for evacuating residents and staff.

2. How was the regulation violated?
Timeframe exceeded the approved evacuation time.

3. What caused the violation?
Fire Drills were done unannounced, and called in to our agency, and went over the maximum time limit. Staff did review why the timeframe was exceeded to determine all factors to determine a root cause. On 10/31/22, we had a resident that was not cooperating in getting in wheelchair and wanting to move. Resident has Parkinsons and Dementia. is generally cooperative and can walk, but was awakened and not comprehending. We were eventually able to get in a wheelchair and get to the fire safe area, but it caused us to go over time. On 2/27/23, we had everyone in back room, but one resident was missing when we did count. We retrieved them from the bathroom, so that made our time go over. On 4/30/23, We had a resident fall, and two other residents fell right after that resident as we were heading to the fire safe zone. It caused us to stop and get them taken care of and then proceed, so the time exceeded. In speaking with our License Inspection Team Supervisor, we reviewed the root cause of fire drill procedure. We continue to do final count of all residents before we call time. This is a factor in our exceeding the time.

4. What can be done right away to fix the violation?
Administration made note on fire drill log of areas that caused the time to be exceeded. We will use two stop watches to conduct fire drills. One stop watch will be used to record when we believe we have all residents and staff n fire safe area. Roll call will be finalized. If someone is not accounted for, we will retrieve them. The second stop watch will be used to record that time.
When time exceeds the maximum timeframe, we will do another fire drill that month, to ensure that we can meet the time frame. We also asked our Fire Chief and team to observe and then educate us on safe evacuation in a timely manner.

5. What can we do to prevent future violations?
Continue to practice fire drills until we can meet the expected timeframe.

132d - Evacuation (continued)

Work with our Fire Chief and team to assist us in this process. The Med Director and Administrator met with our Fire Chief. ██ agreed that ██ and ██ fire team will be in the week of May 29th to observe and provide education with safe and efficient fire drill evacuation.

6. Who will be responsible for preventing future violations?
All staff are responsible to evacuate residents in the allotted timeframe. Administration are responsible that we meet the evacuation timeframe to ensure the safety of the residents and staff.

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

Implemented (██ - 06/22/2023)

132g - Fire Drills Days/Times

5. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home regularly has 2 staff persons working on the overnight shift, however, the following fire drills were conducted with additional staff persons:
** 10/31/22, at 10:05 pm., with 5 staff persons*
** 4/30/23, at 11:00 pm., with 3 staff persons*

Plan of Correction ***Accept (██ - 06/02/2023)***

1. Why is this regulation important?
To provide a safe and effective way of evacuating residents in an emergency situation.

2. How was the regulation violated?
Ensure that residents are evacuated in a timely manner with staff on shift.

3. What caused the violation?
Staff amounts may vary based on shift.

4. What can be done right away to fix the violation?
Maintain 3 staff on all hours of night shift.

5. What can we do to prevent future violations?
Practice with staff and residents fire drills more than one time if timeframe is exceeded. Our Fire Chief and Team will be in the week of May 29th to observe our fire drill process, and will provide education to staff regarding fire drill evacuation.

6. Who will be responsible for preventing future violations?
All staff are responsible for effective and safe fire drills. Personal Care Home Administrators and Med Director are responsible for Fire Drill Log and when fire drills are done and that they meet expected time frames.

132g - Fire Drills Days/Times (continued)

UPDATE JDS 5/29/2023: The schedule since May 15 has included 3 staff persons on the night shift.

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented (- 06/22/2023)

133.1 - Exit Signs

6. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

On 5/2/23 at approximately 11:15 am., there was a "not an exit" sign posted on emergency exit door #3, in the front hallway, giving the impression that the door should not be used in the event of an emergency.

Plan of Correction ***Accept (- 06/02/2023)***

1. Why is this regulation important?
This is important for the residents and staff safety and the public in general.

2. How was the regulation violated?
The door should have stated: Emergency Exit Only.

3. What caused the violation?
t would be confusing to see "Not an Exit," when you could exit that door area. It should be used for emergencies only.

4. What can be done right away to fix the violation?
We met with our Fire Safety Agency to get us a sign that we could post. The sign is hung on door #3. (Upload: Photo of door #3.)

5. What can we do to prevent future violations?
When doing our fire extinguisher checks, we will check for signs on doors to ensure the accuracy of the door usage.

6. Who will be responsible for preventing future violations?
Maintenance Director will be responsible as well as Home Administrator. We met with our CERTA-Site Team who came to the HOME to meet with the Maintenance Director and Personal Care Home Administrator to review the door signage. came in on May 16, 2023. We also met with our construction team and they checked all doors for opening and closing and for signage and entrance and exiting.

UPDATE JDS 5/29/2023: The new exit sign was posted on 5/18/2023. The new sign is Red and White and says: Emergency Exit Only. (Upload of photo showing sign.)

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented (- 06/22/2023)

141b1 - Annual Medical Evaluation

7. Requirements

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

Description of Violation

Resident #3's medical evaluation, dated [redacted]/22, did not include special health/dietary needs. This section was blank.

Resident #4 s most recent medical evaluation was completed on [redacted]/21.

Plan of Correction ***Accept ([redacted] - 06/02/2023)***

1. Why is this regulation important?
Annual Medical Evaluations are necessary for patient wellness.

2. How was the regulation violated?
nformation on Medical Evaluation Form was blank on Resident #3.
Resident #4 Medical Evaluation was completed on [redacted]/2021 by doctor and the form was completed on [redacted] 2022.

3. What caused the violation?
Resident #3 Medical Evaluation was blank under Dietary Needs.
Resident #4 Medical Evaluation Form shows date resident evaluated was [redacted] 2021, with the date form completed being [redacted] 2022. Medical Director spoke with Doctor's office and we confirmed they had chosen not to come to facility due to active COVID.

4. What can be done right away to fix the violation?
Med Director spoke with Doctor's office who confirmed there was no Dietary Need or Restriction for Resident #3. (Upload: Corrected Medical Evaluation.)

Med Director confirmed Resident #4 Medical Evaluation was during Active COVID.. (Upload: New Medical Evaluation Resident #4.)

5. What can we do to prevent future violations?
Administration needs to review more specifically resident Medical Evaluations. Administration needs to connect with Doctor office if clarification is needed.

6. Who will be responsible for preventing future violations?
Medical Director will review each Medical Evaluation first, and then a second review will be done by the Administrative Assistant.

UPDATE JDS 5/29/2023: Resident #4 new Med Evaluation Date is 5/12/2023. (UPLOAD of Resident #4 Medical Evaluation.) Staff meeting was held with administration and a standard operating procedure was put into effect for the Med Director to review all Med Evaluations first, then Administrative Assistant reviews second; then Administrator [redacted] does verification. (UPLOAD Staff Training Minutes.)

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented ([redacted] 06/22/2023)

141b1 - Annual Medical Evaluation *(continued)*

183e Storing Medications

8. Requirements

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

Description of Violation

Resident #5 is prescribed, [redacted] and [redacted]. On 5/3/23, these medications had been opened and were not dated when first opened. According to the manufacturer's instructions, these medications expire 4 weeks after opening.

Plan of Correction ***Accept ([redacted] - 06/02/2023)***

1. Why is this regulation important?
Eye Drops are a medication that needs to be dated upon opening, to establish the expiration date.

2. How was the regulation violated?
[redacted] did not have a date on when they were opened.

3. What caused the violation?
Not dating the [redacted] upon opening.

4. What can be done right away to fix the violation?
[redacted] were disposed and new bottles were dated upon opening. Med Director met with Med Tech team to educate them on the importance of putting a date on the bottle [redacted]. Med Director will review these items as needed, and at the monthly Med Room Meetings.

5. What can we do to prevent future violations?
Educate the Med Tech team on the importance of putting the date on the [redacted] bottle upon opening.

6. Who will be responsible for preventing future violations?
Med Director meets with Med Tech team. Ongoing meetings will include this item as a reminder and review.

UPDATE JDS 5/29/2023: May 15 the Med Director met with all med techs about the importance of the [redacted] being dated and initialed upon opening. Med Director [redacted] will do a weekly review of the carts to ensure this is happening. The Med Director does an audit of all carts monthly. (UPLOAD of minutes of meeting with staff.) The Med Director [redacted] is responsible for meeting with med techs.

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented ([redacted] - 06/22/2023)

191 Resident Right to Refuse

9. Requirements

2600.
191. Resident Education The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

191 - Resident Right to Refuse *(continued)*

Description of Violation

On 5/2/23, resident #3, admitted [redacted]/22 and resident #5, admitted [redacted]/22, had no documentation that the resident had been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 06/02/2023)***

1. Why is this regulation important?
Residents have the right to refuse medications if he/she believes that there may be a medication error.

2. How was the regulation violated?
This information was not listed with our Resident's Rights information.

3. What caused the violation?
We printed new forms from the DHS website on resident rights, so that we would have nice clean copies and forgot to add our Letter Z stating that we review and educate the resident on the right to refuse medication if the resident believes there may be a medication error.

4. What can be done right away to fix the violation?
We removed all copies in our admission package of the Resident Rights that do not include our section Z, which ndicates: We review and educate residents on the Resident's right to refuse medication if the resident believes that there may be a medication error. (Upload: Form that shows Section Z.)

5. What can we do to prevent future violations?
We made a note on our Admissions Checksheet that we need to make sure Resident's Right form includes Section Z with our statement and to include their signature and date. (Upload: Admissions Checksheet with added section.)

6. Who will be responsible for preventing future violations?
Personal Care Home Administrator reviews the check list and so we can check this section was completed.

UPDATE JDS 5/29/2023: 5/25/2023 Resident #3 signed the form about receiving an education about the right to refuse medication if they feel there may be a medication error.. Unfortunately, Resident #5 passed away on [redacted]/2023, therefore, we have no ability to follow-up.

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented ([redacted] - 06/22/2023)

225a - Assessment 15 Days

10. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

On 5/2/23. resident #5's assessment, dated [redacted]/23, indicated the resident is [redacted], however, the resident requires [redacted] with all transfers for safety.

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Accept (JW 06/02/2023)***

1. Why is this regulation important?
Resident mobility status is important for proper resident care.

2. How was the regulation violated?
Resident RASP states [redacted] when Inspector felt it should be [redacted]).

3. What caused the violation?
Difference in opinion of Mobility of Resident #5.

4. What can be done right away to fix the violation?
After discussion with Inspector, the Personal Care Home Administrators and Med Director agreed to list Resident #5 as [redacted]) (Upload: RASP paperwork showing the change in Mobility status.)

5. What can we do to prevent future violations?
Discussion with Doctor when 2 Assist or Special Needs of Resident for mobility is needed.

6. Who will be responsible for preventing future violations?
Personal Care Home Administrators and Med Director. Med Director and Doctor meet every month with residents. Med Director and Doctor will discuss resident mobility needs and changes each month.

UPDATE JDS 5/29/2023: It was updated by the Administrative Assistant [redacted] and verified by Med Director [redacted] We only have one, 2 assist resident and [redacted] is listed as #5 for this report, but there is already a #5 assigned to another resident in this report, so we are assuming this RESIDENT can be referred to as Resident #1. We know the privacy coding sheet will need to reflect this resident. (Upload of Resident #5 RASP that was updated.)

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented ([redacted] - 06/22/2023)

225c - Additional Assessment

11. Requirements

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

Description of Violation

On 5/2/23, resident 2's assessment, dated [redacted]/22, indicates the resident can self-administer medications with assistance in remembering schedule. However, the resident's medical evaluation, dated [redacted]/22, indicates the resident cannot self-administer medications except for a doctor's order indicating the resident can self-administer the medication [redacted]

On 5/2/23, resident #3's assessment, dated [redacted]23, does not indicate the level of need for communicating needs, understanding instructions, short/long term memory, and the ability to use/avoid poisonous material. These areas were blank.

225c - Additional Assessment (continued)

Plan of Correction ***Accept (JW - 06/02/2023)***

1. Why is this regulation important?
A Resident's Assessment Plan provides a roadmap of the resident's individual care plan for the staff to follow.

2. How was the regulation violated?
Conflicting information regarding Resident #2 ability to self-administer
Missing (Blank) information for Resident #3 on Rasp Section of Communicating needs, understanding instructions, short/long term memory, and the ability to use/avoid poisonous material.

3. What caused the violation?
Conflicting information Resident #2 Assessment and Resident Medical Evaluation regarding self-administration of

Missing (Blank) information on Resident #3 RASP.

4. What can be done right away to fix the violation?
Resident #2 cannot self-administer per doctor.l Evaluation states " Meds."(Upload: Doctor's Order.)

Resident #3 had one section of the Assessment missing (Blank). We are unsure of what happened because our working papers show we have that section completed, but the copy in the file shows this section blank. (Upload: Assessment with corrected blank section.)

5. What can we do to prevent future violations?
A first review of Assessments with the Medical Director and a second review with Administrative Assistant.

6. Who will be responsible for preventing future violations?
Medical Director and Administrative Assistant

UPDATE JDS 5/29/2023: Resident #2 Assessment was updated on 5/26/2023. Resident #3 Assessment was updated on 5/26/2023. (Upload of Resident #2 and Resident #3 Updated Assessments with dates that they were updated.)

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented (- 06/22/2023)

227d - Support Plan Medical/Dental

12. 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.

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

Description of Violation

On 5/2/23, resident #4s support plan, dated 23, did not document how the need will be met.

Plan of Correction ***Accept (- 06/02/2023)***

1. Why is this regulation important?
Support Plan is a tool for the Home staff to monitor and assist residents.

2. How was the regulation violated?
We failed to list the resident's as part of their care plan.

3. What caused the violation?
Failure to list as a piece of necessary equipment used to care for resident.

4. What can be done right away to fix the violation?
Home Administrator and Med Director reviewed equipment for residents and double checked RASPS for accuracy. Update our Internal Questions regarding Resident Equipment. Corrected RASP to include the for Resident #4. (Upload: Our Internal Question List; Corrected RASP for Resident #4 .

5. What can we do to prevent future violations?
We have a list of things we ask residents and families, we will add to this list of items to review.

6. Who will be responsible for preventing future violations?
Administrator and Medical Director will work together to prevent future violations. Screening Questions that we use nternally was updated. Med orders are given if equipment is added after resident is in the Home.

UPDATE JDS 5/29/2023: Resident # 4 Assessment was updated on 5/26/2023 to include the . Our internal Questionnaire sheed was updated to add . (Upload Resident #4 Assessment with date it was updated. Upload Internal Questionnaire to show we added .)

Licensee's Proposed Overall Completion Date: *05/29/2023*

Implemented (- 06/22/2023)