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

July 10, 2023

[redacted], ADMINISTRATOR
SZR ABINGTON AL OPCO LLC
[redacted]

RE: SUNRISE OF ABINGTON
1841 SUSQUEHANNA ROAD
ABINGTON, PA, 19001
LICENSE/COC#: 14488

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/13/2023, 03/14/2023, 03/15/2023 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: *SUNRISE OF ABINGTON* **Licen e #**: *14488* **Licen e Expiration**: *01/01/2024*

Address: *1841 SUSQUEHANNA ROAD, ABINGTON, PA 19001*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SZR ABINGTON AL OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/02/2010* **Issued By**: *Abington Township*

Staffing Hours

Resident Support Staff: *73* **Total Daily Staff**: *190* **Waking Staff**: *143*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/15/2023*

Inspection Dates and Department Representative

03/13/2023 - On-Site: [redacted]
03/14/2023 - On-Site:
03/15/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: *110* **Re ident Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminiscence* **Capacity**: *24* **Re ident Served**: *17*

Hospice

Current Re ident : *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *73*
Diagnosed with Mental Illness: *4*
Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *44*
Have Physical Disability: *2*

Inspections / Reviews

03/13/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/07/2023*

Inspections / Reviews *(continued)*

04/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/18/2023*

Reviewer [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/18/2023*

04/21/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/18/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/18/2023*

07/10/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/18/2023*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1 is prescribed [redacted]. This medication was not administered on [redacted]/23 because the medication was not available. The home did not report this medication error to the department.

Resident #1 is prescribed [redacted]. This medication was not administered on [redacted]/23 and [redacted]23 because the medication was not available. The home did not report this medication error to the department.

Resident #1 is prescribed [redacted]. This medication was not administered on [redacted]23 because the medication was not available. The home did not report this medication error to the department.

Resident #2 is prescribed [redacted]. This medication was not administered on [redacted]/23 because the medication was not available. The home did not report this medication error to the department.

Resident #3 is prescribed [redacted] tablet by mouth one time per day. The home has a medication package of 40mg tablets. Medication Staff have been administering 1 tablet of [redacted] to the resident for an unknow length of time. The home did not report this medication error to the department.

Plan of Correction ***Accept ([redacted] - 04/21/2023)***

4/6/2023-The Resident Care Director submitted the incident report for the medication errors for Residents 1,2, and 3.
4/6/2023-The Resident Care Director reviewed the administration records for residents to verify no other medication errors were found and required reporting. No additional errors identified.
4/18/2023-The Executive Director reeducated the Resident Care Director and Wellness team on timely reporting of incidents related to medications errors, specifically medications not available/pending delivery.
4/6/2023 & ongoing-The Resident Care Director will check the medication administration record daily to verify there are no medication errors to report due to medication not available/pending delivery within the last 24 hours.
4/6/2023 &ongoing-The Executive Director or designee will discuss and review reportable incidents, including those due to medication not available/pending delivery, during the morning meeting to verify they were reported timely.
4/7/2023 & for three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

16c - Written Incident Report (continued)

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented (- 07/10/2023)

42s Privacy

2. Requirements

2600.
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

On /23 at am, there were video cameras located outside exits from the home's smoking room, bird room, stairwell C, and garden. There were no signs posted by these cameras indicating video surveillance.

On /23 at am, staff person A was observed having a conversation with resident #4 about the resident's medication in the first floor dining area. There were other residents present in the dining room at the time.

Plan of Correction ***Accept (04/21/2023)***

3/13/2023-The Associate Executive Director created signs and hung outside the smoking room, bird room, stairwell C, and garden areas.
3/13/2023-Executive Director & Director of Environmental Services did a thorough walk around the property to ensure signs were hung wherever cameras were located.
3/13/2023-Executive Director or designee will continue to check to ensure signs are hung where cameras are located during weekly rounds.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

3/15/2023-Staff member A involved with speaking with resident #4 was immediately re-educated by the Executive Director on the privacy rights of residents and not speaking about a resident's medical needs in front of others.

4/4/2023- Direct Care team members were reeducated by the Executive Director on respecting privacy of all residents and not speaking about their medical needs in front of others.
4/4/2023-The Executive Director will review with the team during monthly town hall meeting about respecting resident privacy.
4/18/2023- For the next three months, periodic observations of direct care staff will be conducted by the Executive Director or designee to monitor direct care staff and resident interactions to verify resident's right to privacy.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

42s - Privacy *(continued)*

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented (- 07/10/2023)

60b - Additional Staffing

3. Requirements

2600.
60.b. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the home and the operation and management of the home.

Description of Violation

Resident interviews and the call bell report revealed staff response times to call bells are long.
On /23 at pm, Resident 12 used their call bell to request assistance to the toilet. The Call bell alerted 8 times but was not responded to for 39 minutes.
On /23 at , Resident 9 used their call bell. The call bell alerted 8 times but was not responded to for 38 minutes.
On /23 at am Resident 3 used their call bell. the call bell alerted 5 times but was not responded to for 21 minutes.
Residents who require help with toileting wait more than 20 minutes for assistance on a regular basis. Staff interviews revealed that there are not enough staff available to answer the volume call bells that are received.

Repeat Violation: 9/20/21, et al and 10/7/21.

Plan of Correction ***Accept (- 04/21/2023)***

3/15/2023-The Resident Assessments and Support Plans for residents #3, 9, and 12 were reviewed by the Care Coordinators to verify accuracy of resident needs, which directly impacts scheduling of staff. The Assessments and Support Plans for residents #3, 9, and 12 were found to be accurate.
3/15/2023- The Executive Director and Care Coordinators reviewed the staffing schedule to verify that there are sufficient number of staff scheduled to meet the needs of the residents.
3/15/2023- The call bell report was reviewed by the Executive Director and Associate Executive Director with the Personal Care Coordinator to determine if there were any additional residents with high call bell response times that would require an additional review to determine cause.
4/21/2023-The Executive Director provided additional training with the Direct Care staff on the proper use of the call bell system and communicating a change of condition for residents for observation made during provision of care.
3/15/2023- The Executive Director or designee review daily with the care coordinators the staffing for the community to verify enough direct care staff are scheduled.
3/15/2023- The call bell report is reviewed daily in the team stand up meeting and any extended response times are reviewed and discussed by the Executive Director and Coordinators.
3/15/2023-Weekly the Care Coordinators reviews resident changes of condition to identify any changes that would mpact staffing requirements. The staffing schedule is adjust based on resident needs.
4/7/2023 & for up to three months-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

Licensee's Proposed Overall Completion Date: *04/18/2023*

60b - Additional Staffing *(continued)*

Implemented (- 07/10/2023)

65a - FS Orientation 1st Day

4. Requirements

2600.

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

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

Description of Violation

Staff person B, whose first day of work was /22, did not receive orientation on the following topics until /22:

(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.

Plan of Correction ***Accept (- 04/21/2023)***

The community respectfully requests that this violation, 65a, be withdrawn. Staff member B was hired on /22, but their first day in the community was /22 and staff person completed their first day orientation requirements on /2022.

f our request is not approved the following POC will be implemented:

9/16/2022- Staff person B was hired on /2022. Staff person B's first day of work in the community was on /2022. On their first day Staff person B received orientation on the following topics:

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.

65a - FS Orientation 1st Day (continued)

5) The location and use of fire extinguishers.
6) Smoke detectors and fire alarms.
7) Telephone use and notification of emergency services.
3/15/2023-The Business Office Coordinator reviewed the staff that was hired in 2022 and verified the staff persons had completed first day of orientation in general fire safety and emergency preparedness, and topics listed under 65a.
4/18/2023-The Executive Director will meet with the Business Office Coordinator and review the requirements for new employee completing first day of orientation in general fire safety and emergency preparedness, and topics isted under 65a.
4/18/2023 & ongoing-The Business Office Director or designee will review new employees training documentation monthly and verify all required training and documentation has been completed. The Business Office Coordinator will report the outcomes of the review during the monthly QAPI meeting.
4/18/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented (- 07/10/2023)

65d - Initial Direct Care Training

5. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
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
iii. Personal hygiene.
iv. Care of residents with dementia, mental illness, cognitive 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 home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. 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 home.

Description of Violation

Direct care staff person C, hired on /21, began providing unsupervised ADL services on or about /21

65d - Initial Direct Care Training (continued)

. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept (- 04/21/2023)***

3/14/2023- Team Member C was made aware that initial direct care training must be completed and could not provide care until training was complete.
3/21/2023-Team Member C completed initial indirect training. (Team Member C has been in nursing school since 2022).
3/15/2023-The Business Office Coordinator conducted an audit of all team member files to verify initial indirect training has been completed as necessary.
3/15/2023-Upon hire of a new employee the Business Office Coordinator will schedule the new employee for Initial direct care staff person training and the new employee will not be placed on the schedule until the training is completed.
4/7/2023 & three months ongoing-The Business Office Director or designee will review new employees training documentation monthly and verify all required training and documentation has been completed. The Business Office Coordinator will report the outcomes of the review during the monthly QAPI meeting.
-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented (- 07/10/2023)

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
3. Initial direct care staff person training to include the following:

Description of Violation

Direct care staff person C, hired on /21, began providing unsupervised ADL services on or about /21. However, the staff person did not complete the following initial direct care staff person training:
(i) Safe management techniques.
(ii) ADLs and IADLs.
(iii) Personal hygiene.
(iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation 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 home.
(xii) Safety management and hazard prevention.

65d - Initial Direct Care Training (continued)

(xiii) Universal precautions.
(xiv) The requirements of this chapter.
(xv) Infection control.
(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Plan of Correction ***Accept [redacted] 04/21/2023)***

3/22/2023-Team member C was made aware that Medication Self-Administration training and Instruction on Meeting the
Needs of Residents as described in the Preadmission Screening Form, DME and RASP, needed to be completed. Team member C completed the training.
4/7/2023-The Business Office Coordinator conducted an audit of training records to verify direct care staff have completed training on Medication Self-Administration training and Instruction on Meeting the Needs of Residents as described in the Preadmission Screening Form, DME and RASP.
3/22/2023- Annually the Executive Director and Coordinators review the annual training plan to verify all required topics have been included and to share the training schedule.
3/22/2023- As trainings occur the Business Office Coordinator reviews the training sign-in sheets to verify staff have completed the training. If there are staff identified to be missing the training additional training days for the specific topic will be made available and the staff persons will be scheduled to complete the training.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented [redacted] - 07/10/2023)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Direct care staff person C did not receive training in medication self-administration and instruction on meeting the needs (DME & RASP) during training year 2022.

Plan of Correction ***Accept ([redacted] - 04/21/2023)***

3/22/2023-Team member C was made aware that Medication Self-Administration training and Instruction on Meeting the
Needs of Residents as described in the Preadmission Screening Form, DME and RASP, needed to be completed. Team member C completed the training.

65f - Training Topics (continued)

4/7/2023-The Business Office Coordinator conducted an audit of training records to verify direct care staff have completed training on Medication Self-Administration training and Instruction on Meeting the Needs of Residents as described in the Preadmission Screening Form, DME and RASP.
3/22/2023- Annually the Executive Director and Coordinators review the annual training plan to verify all required topics have been included and to share the training schedule.
3/22/2023- As trainings occur the Business Office Coordinator reviews the training sign-in sheets to verify staff have completed the training. If there are staff identified to be missing the training additional training days for the specific topic will be made available and the staff persons will be scheduled to complete the training.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented [redacted] - 07/10/2023)

85a - Sanitary Conditions

8. Requirements

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

Description of Violation

On [redacted]/23 at [redacted] am, in the 2nd floor computer room, there was a discarded coffee cup and soda can in the far-right corner of the room next to an armchair.

Plan of Correction ***Accept ([redacted] - 04/13/2023)***

3/13/2023-The coffee cup and soda can were discarded immediately by the Director of Environmental Services.
3/13/2023-The Executive Director and Director of Environmental Services did a thorough sweep of the community and all common areas to ensure there was no trash or discarded items visible.
3/13/2023 & ongoing daily-The Executive Director or designee will ensure the community is neat and all trash is discarded during daily rounds of the community.
4/4/2023-The Executive Director reeducated the team at the monthly town hall meeting on discarded trash and kitchenware as needed.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

Licensee's Proposed Overall Completion Date: *04/07/2023*

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

85e - Trash Outside Home

9. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

85e - Trash Outside Home *(continued)*

Description of Violation

On 3/13/23, at 10:18 am, there were 2 dumpsters and 3 trash cans behind the home that were not covered. Trash was overflowing and there were several bags of trash on the ground.

Repeat Violation: 9/20/21 et al.

Plan of Correction ***Accept (- 04/13/2023)***

3/13/2023-The Director of Environmental Services called the waste management vendor to ensure the trash was picked up that day and dumpster was emptied.
3/13/2023-The Director of Environmental Services coordinated a third pick up day of trash with the waste management vendor.
3/13/2023 & ongoing-The Director of Environmental Services, Executive Director, or designee will check the dumpster during daily rounds to ensure lids are closed and trash has been picked up when scheduled.
4/7/2023 & three months ongoing- The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (- 07/10/2023)

95 - Furniture and Equipment

10. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The handle for the cold water on the kitchenette sink in room 115 requires extra force to turn on.

Plan of Correction ***Accept (- 04/13/2023)***

3/14/2023-The Director of Environmental Services fixed the kitchenette sink.
3/14/2023-The Director of Environmental Services did random audit of all kitchenette sinks in apartments to ensure they were working properly.
4/7/2023 & ongoing-The Director of Environmental Services will conduct a random audit of all kitchenette sinks to ensure that they are functional.
3/14/2023 & ongoing-The Director of Environmental Services and Executive Director will randomly check kitchenette sinks during daily rounds to ensure functionality.
4/7/2023 & three months ongoing- The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (- 07/10/2023)

101o - Walls, Floors, Ceilings

11. Requirements

101o - Walls, Floors, Ceilings *(continued)*

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The wall in room 115 has a large hole, to the left of the entrance.

Plan of Correction ***Accept ([redacted] - 04/13/2023)***

3/14/2023 The maintenance team spackled and patched the hole in the apartment wall.
3/17/2023 The Director of Environmental Services conducted an audit of all apartments to ensure all walls were inished, clean, and in good repair.
4/7/2023 The Director of Environmental Services will conduct a random audit of all apartments to ensure there are no holes in the walls.
3/17/2023 & ongoing The Director of Environmental Service, the Executive Director, or designee will check to ensure all walls, floors, and ceilings are finished, clean and in good repair during daily rounds.
4/7/2023 & three months ongoing The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented [redacted] - 07/10/2023)

103c - Food Protected

12. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 3/14/23 at 2:42 pm there was a bag of mini hash browns not sealed and a tray of veggie burgers uncovered in the walk-in refrigerator

On 3/14/23 at 2:42 pm, in the dry storage area, there were 2 unsealed squeeze bottles of Smuckers Dessert Topping and an unsealed box of white cake mix.

Plan of Correction ***Accept ([redacted] - 04/13/2023)***

3/14/2023 The mini hashbrowns, veggie burgers, Smuckers dessert topping, and white cake mix were all discarded nto the garbage.
3/14/2023 The Director of Dining Services conducted an audit of all walk ins and storage areas to ensure proper sealing, labeling, and dating of product.
3/15/2023 & ongoing The Director of Dining Services and Executive Director will randomly audit the walk ins and storage areas to ensure proper sealing, labeling and dating of all products.
4/4/2023 The dining team was re educated on the importance of protecting food, and proper storage, sealing, and abeling of food.
4/7/2023 & three months ongoing The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective

103c - Food Protected (continued)

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (- 07/10/2023)

103e - Left Overs

13. Requirements

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

Description of Violation

On 3/13/23 at 10:35 am, there was unlabeled and undated leftover cake and leftover applesauce, in the refrigerator in the Reminiscence kitchenette.

Plan of Correction ***Accept - 04/13/2023)***

3/13/2023-The cake and leftover applesauce were discarded by the Reminiscence Coordinator.
3/13/2023 & ongoing-The Reminiscence Coordinator did a check of the refrigerator daily during her rounds in the neighborhood.
3/13/2023 & ongoing-The Executive Director or designee will do a check of all refrigerators to ensure any leftovers are labeled and dated during daily rounds.
4/4/2023-The team was re-educated on labeling and dating leftovers in the refrigerator during town hall.
4/7/2023 & three months ongoing- The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (- 07/10/2023)

103f - Refrigerator/Freezer Temps

14. Requirements

2600.
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

The ice cream freezer does not have a thermometer.

Plan of Correction ***Accept (- 04/21/2023)***

3/14/2023-The community located a thermometer and placed it in the freezer.
3/14/2023 & ongoing-The Director of Dining Services or designee will ensure during daily rounds that the freezer has a thermometer at all times.
3/14/2023 & ongoing-The Executive Director or designee will do random weekly audits of all walk ins and refrigerators to ensure they have proper and working thermometers.
4/7/2023-All refrigerators and freezers currently have functioning thermometers.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure

103f - Refrigerator/Freezer Temps (continued)

it is still effective

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented [redacted] - 07/10/2023)

103g - Storing Food

15. Requirements

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

Description of Violation

On 3/14/23 at 2:42 pm there was a bag of mini hash browns not sealed and a tray of veggie burgers uncovered in the walk-in refrigerator

On 3/14/23 at 2:42 pm, in the dry storage area, there were 2 unsealed squeeze bottles of Smuckers Dessert Topping and an unsealed box of white cake mix.

Plan of Correction ***Accept [redacted] - 04/21/2023)***

3/14/2023-The mini hashbrowns, veggie burgers, Smuckers dessert topping, and white cake mix were all discarded into the garbage.
3/15/2023 & ongoing-The Director of Dining Services conducted an audit of all walk ins and storage areas to ensure proper sealing, labeling, and dating of product.
3/15/2023 & ongoing-The Director of Dining Services and Executive Director will conduct weekly random audits of the walk ins and storage areas to ensure proper sealing, labeling and dating of all products.
4/4/2023 & ongoing-The dining team was re-educated on the importance of protecting food, and proper storage, sealing, and labeling of food.
4/7/2023 & three months ongoing- The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented [redacted] - 07/10/2023)

103i - Outdated Food

16. Requirements

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

Description of Violation

On 3/14/23, there was an unlabeled, undated tub of fruit salad in the dessert refrigerator.

On 3/14/23, there was an unlabeled, undated bag of peeled garlic in the walk-in refrigerator.

103i - Outdated Food (continued)

On 3/14/23, in the walk-in freezer, there was a stack of pie crust wrapped in plastic wrap, a bag of pepperoni, a bag of meatball, a bag of shrimp, a bag of hashbrowns, a bag of chopped spinach, and a bag of corn. All were not labeled and not dated.

On 3/14/23, in the dry storage area, there were three large tubs with breadcrumbs, flour, and sugar that were not dated.

On 3/14/23, there were 2 dented cans of sliced peaches in the dry storage area.

On 3/14/23, there were 2 open squeeze bottles of Smuckers Dessert Topping, an open box of white cake mix, and several bags of pasta, including macaroni, penne, and ziti that were not dated.

Plan of Correction ***Accept (04/13/2023)***

3/14/2023-All opened, unlabeled food and all dented cans were discarded into the garbage.
3/15/2023-The Director of Dining Services conducted an audit of all walk ins and storage areas to ensure proper labeling, and dating of items while also ensuring that cans were not dented.
3/15/2023 & ongoing-The Director of Dining Services will conduct a weekly audit of all walk ins and storage areas to ensure proper labeling, and dating of items while also ensuring that cans are not dented.
4/5/2023-The dining team was re-educated on the importance of protecting food, and proper storage, sealing and labeling of food.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (- 07/10/2023)

107d - Procedure Emergency Management Agency Submission

17. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted.

Plan of Correction ***Accept (- 04/13/2023)***

3/17/2023-The emergency written procedures was submitted to the local emergency management agency.
3/17/2023-The Executive Director audited the emergency procedures plan to ensure it was complete and accurate.
3/17/2023 & ongoing-The Executive Director will review the emergency procedures plan monthly to ensure effectiveness and accuracy.
4/7/2023 & three months ongoing- The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure

107d - Procedure Emergency Management Agency Submission (continued)

it is still effective

Licensee's Proposed Overall Completion Date: *04/07/2023*

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

109b - Rabies Vaccination

18. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

The home does not have a current certificate of rabies vaccination for the 2 cats in room 304 .

Plan of Correction ***Accept ([redacted] - 04/13/2023)***

3/13/2023-The community contacted the family of this resident to inform them an updated rabies vaccination was needed for both pets.
3/24/2023-The family arrived to the community and took the pets to the veterinarian for current vaccines.
3/24/2023-The community received an updated vaccination record for both pets and filed it in the community pet vaccination folder.
3/24/2023 & ongoing-The Activities Coordinator and Executive Director will audit the vaccination folder monthly to ensure all pets vaccinations are current.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

Licensee's Proposed Overall Completion Date: *04/07/2023*

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

132a - Monthly Fire Drill

19. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the months of December 2021, January 2022, February 2022, April 2022, May 2022, June 2022, July 2022, and August 2022.

Plan of Correction ***Accept ([redacted] - 04/13/2023)***

9/30/2022-The community has had monthly fire drills since September, 2022.
3/15/2023 & ongoing-The Executive Director and Director of Environmental Services will schedule monthly fire drills to ensure compliance.
3/15/2023 & ongoing-The Director of Environmental Services will record all fire drills according to date and time.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective

132a - Monthly Fire Drill (continued)

Licensee's Proposed Overall Completion Date: *04/07/2023*

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

132g - Fire Drills Days/Times

20. 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 routinely holds fire drills at the end of the month as evidenced by the following drills: 9/29/22, 10/28/22, 11/30/22, 12/27/22, 1/30/23, and 2/26/23.

Plan of Correction ***Accept ([redacted] - 04/13/2023)***

4/1/2023 & ongoing-The community will continue to conduct monthly fire drills, however, they will be scheduled during different times of the month as not to be at the same range of dates at the end of each month.
4/1/2023 & ongoing-The Director of Environmental Services will work with the Executive Director to ensure fire drills are scheduled at different times of the month.
4/15/2023-The Director of Environmental Services will conduct a fire drill not during the end of the month.
4/1/2023 & ongoing-The Director of Environmental Services will continue to record all fire drills conducted in the community.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

Licensee's Proposed Overall Completion Date: *04/07/2023*

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

144c1 - Smoking Area Guidelines

21. Requirements

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

Description of Violation

The smoking room does not have a receptacle for cigarettes.

Plan of Correction ***Accept ([redacted] - 04/13/2023)***

3/13/2023-The community put an ashtray in the smoking room.
3/13/2023 & ongoing-The Executive Director or designee will check the smoking room daily during rounds to ensure a proper receptacle is in place for cigarettes.
4/6/2023-The Executive Director conducted a random check of the smoking room to ensure the ashtray was still

144c1 - Smoking Area Guidelines (continued)

available.
4/7/2023 & ongoing- The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (- 07/10/2023)

144d Smoking Outside

22. Requirements

2600.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 3/13/23 at 10:19 am, there were several discarded cigarette butts on top of the trash near the dumpsters and on top of a grease can. The home's designated smoking areas are the smoking room and in the back of the home.

Plan of Correction ***Accept (- 04/13/2023)***

3/13/2023- The community cleaned the cigarette butts from the areas outside.

3/13/2023 & ongoing-The Director of Environmental Services conducted an audit of the outside grounds to ensure there were no discarded cigarette butts.

3/13/2023 & ongoing-The Director of Environmental Services or designee will conduct daily rounds of the outside grounds to ensure there are no discarded cigarette butts.

4/4/2023- The Executive Director reeducated the team on smoking on grounds and proper discarding of cigarette butts.

4/7/2023 & three months going-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (- 07/10/2023)

181d Storing Medication

23. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident s room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #4 self-administers medications and stores medications in his/her room. On /23 pm, there were several unlocked, unattended medications to include in resident #4's bedroom.

181d -Storing Medication *(continued)*

Plan of Correction ***Accept (04/13/2023)***

3/14/2023-The Resident Care Director and Wellness team removed the medications from the resident's apartment.
3/15/2023-The RCD conducted an audit of all self-medicating residents to ensure proper storage of medication.
3/22/2023 & ongoing-Resident Care director educated MCM/Nurses on proper medication storage for self medicating residents. .
3/15/2023 & ongoing-Nurses will conduct monthly audits of self medicating residents to ensure proper storage of medications.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (- 07/10/2023)

183e - Storing Medications

24. 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

In resident #4's room, there were 4 loose pills (light orange oval) on the floor in front of the kitchenette sink. On the floor next to the resident's bed there was a loose round pink pill and a loose pill that appears to match the pills in a bottle of Apap/Codeine nearby.

Plan of Correction ***Accept 04/13/2023)***

3/14/2023-The Resident Care Director and Wellness team removed the medications from the resident's apartment.
3/15/2023-The RCD conducted an audit of all self-medicating residents to ensure proper storage of medication.
3/22/2023 & ongoing-Resident Care director educated MCM/Nurses on proper medication storage for self medicating resdients. .
3/15/2023 & ongoing-Nurses will conduct monthly audits of self medicating residents to ensure proper storage of medications.
4/7/2023 & ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (07/10/2023)

184a - Resident's Meds Labeled

25. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

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

Description of Violation

Resident #5 is prescribed [redacted], take 1.5 tablet by mouth two times a day for 7 days. The pharmacy label on the medication reads [redacted] 3 tabs by mouth twice daily for 7 days.

Resident #6 is prescribed [redacted] tablet by mouth two times daily. The pharmacy label on the medication reads, [redacted], take 1 tablet by mouth two times a day.

Plan of Correction ***Accept ([redacted] - 04/13/2023)***

3/15/2023 & ongoing-The Medication Care Managers and Wellness Nurses ensured all labels and eMars matched.
3/15/2023 & ongoing-The Wellness team will conduct weekly audits to ensure pharmacy labels match the MAR.
3/22/2023-The Resident Care Director reeducated Medication Care Managers and Wellness Nurses on process of matching the pharmacy label to the MAR.
4/7/2023 & ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective

Licensee's Proposed Overall Completion Date: *04/07/2023*

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

185a Implement Storage Procedures

26. Requirements

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

Description of Violation

The Medication Administration report for resident #7 has a blood glucose reading of [redacted] for [redacted] /23 at [redacted]. This reading is not on the resident's glucometer.

Plan of Correction ***Accept ([redacted] 04/13/2023)***

3/15/2023-The Resident Care Director audited all glucometers to ensure accuracy and recording of reading. The Resident Care Director conducted cart audits to ensure all medications ordered were on the cart and not expired.
3/15/2023 & ongoing-The Resident Care Director will conduct weekly glucometer audits to ensure accuracy on documentation. Medication Care Managers/Nurses will conduct weekly cart audits.
3/22/2023 -The Medication Care Managers and Wellness team were re-educated during team meeting on steps to follow when medications are discontinued and when medication doses change.
4/7/2023 & ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective

Licensee's Proposed Overall Completion Date: *04/07/2023*

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

27. 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 #2 is prescribed [redacted] and Docusate Sodium as needed. On [redacted]/23 these medications were not available in the home.

Plan of Correction ***Accept ([redacted] - 04/13/2023)***

3/15/2023-The Resident Care Director audited all glucometers to ensure accuracy and recording of reading. The Resident Care Director conducted cart audits to ensure all medications ordered were on the cart and not expired.
3/15/2023 & ongoing-The Resident Care Director will conduct weekly glucometer audits to ensure accuracy on documentation. Medication Care Managers/Nurses will conduct weekly cart audits.
3/22/2023-The Medication Care Managers and We lness team were re-educated during team meeting on steps to follow when medications are discontinued and when medication doses change.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective

Licensee's Proposed Overall Completion Date: *04/07/2023*

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

187a - Medication Record

28. 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

Resident #7 is prescribed [redacted], 2 tabs by mouth every 4 hours as needed for temp. This medication is not on the Medication Administration Record.

Plan of Correction ***Accept [redacted] - 04/13/2023)***

3/15/2023-The Resident Care Director conducted an audit to ensure all medications ordered for residents are on the MAR.
3/15/2023 & ongoing-The Medication Care Managers/Wellness Nurse will conduct weekly cart checks to ensure all medications are on the residents' MAR.
3/22/2023-The Medication Care Managers and We lness Nurses were re-educated by the Resident Care Director on ensuring all medications are on the MAR.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective

Licensee's Proposed Overall Completion Date: *04/07/2023*

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

187d - Follow Prescriber's Orders

29. Requirements

2600.

187d - Follow Prescriber's Orders *(continued)*

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

Description of Violation

Resident #3 is prescribed [redacted] by mouth one time per day. The home has [redacted] on the medication cart for the resident. The home has been administering 1 40mg tablet daily for an unknow length of time.

Resident #7 is prescribed [redacted], inject as per sliding scale: 140-180= 1 unit; 181-220=2 units; 221-260= 3 units; 261-300= 4 units; 301-340= 5 units; 341-380= 6 units; 381-400= 7 units; subcutaneously three times per day. On 3/14/23 at 1700, The resident's blood glucose level was not checked and no insulin was administered.

Repeat Violation Date: 9/20/21 et al.

Plan of Correction ***Accept ([redacted] - 04/21/2023)***

3/16/2023-The Resident Care Director verified Resident #3's medication order for [redacted], 1 tablet by mouth one time per day and corrected the medication administration record. Resident #3's physician was notified, and resident assessed. No adverse effects identified.
3/16/2023-Resident #7's physician was notified, and resident assessed. No adverse effects identified.
3/16/2023-The Resident care Director met with the medication administration staff and review the medication errors and medication administration procedures.
3/16/2023-The Resident Care Director reviewed the medication administration records to verify orders are accurately transcribed and medications are being administered.
3/16/2023-The Resident Care Director will check the medication administration record daily to verify medications are being administered.
3/16/2023-The Medication Care Managers or designee conduct weekly medication administration record to medication cart audits to verify medications are being administered according to orders.
3/16/2023-The Resident care Director or designee conduct monthly medication administration record to medication cart audits to verify medications orders are transcribed correctly, and medications are being administered according to orders.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

Licensee's Proposed Overall Completion Date: *04/18/2023*

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

30. Requirements

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

Description of Violation

Resident #1 is prescribed [redacted]. This medication was not administered on [redacted]/23 because the medication was not available.

Resident #1 is prescribed [redacted]. This medication was not administered on [redacted] because the medication was not available.

187d - Follow Prescriber's Orders (continued)

Resident #1 is prescribed [redacted]. This medication was not administered on [redacted]23 because the medication was not available.

Resident #2 is prescribed [redacted]. This medication was not administered on [redacted]23 because the medication was not available.

Repeat Violation Date: 9/20/21 et al.

Plan of Correction ***Accept ([redacted] 04/21/2023)***

The Resident Care Director ensured the medications were available for administration for Residents #1 and Resident #2.

3/16/2023- Resident Care Director to conduct audit from March 1st to current to ensure medication was ordered and currently in cart.
3/16/2023 & ongoing- Resident Care Director and Wellness Nurse will review the Medication administration dashboard in eMar daily to verify there are no missed administrations.
3/16/2023 & ongoing-Nurse and or Med Tech will conduct weekly cart audits.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented ([redacted] 07/10/2023)

188b - Medication Error Reporting

31. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 is prescribed [redacted]. This medication was not administered on [redacted]/23 because the medication was not available. The home did not report this medication error to the resident, the resident's designated person and the prescriber.

Resident #1 is prescribed [redacted] This medication was not administered on [redacted] because the medication was not available. The home did not report this medication error to the resident, the resident's designated person and the prescriber.

Resident #1 is prescribed [redacted]. This medication was not administered on [redacted] because the medication was not available. The home did not report this medication error to the resident, the resident's designated person and the prescriber.

Resident #2 is prescribed [redacted]. This medication was not administered on [redacted] because the medication was not available. The home did not report this medication error to the resident, the

188b - Medication Error Reporting (continued)

resident's designated person and the prescriber.

Resident #3 is prescribed [redacted] 1 tablet by mouth one time per day. The home has been administering 1 tablet of [redacted] to the resident. The home did not report this medication error to the resident, the resident's designated person and the prescriber.

Plan of Correction ***Accept [redacted] - 04/21/2023)***

3/15/2023-Resident Care Director notified resident 1's designee, the prescriber, and the resident of the medication error.
3/15/2023-Resident Care Director notified resident 2's designee, the prescriber, and the resident of the medication error.
3/15/2023-Resident Care Director notified resident 3's designee, the prescriber, and the resident of the medication error.
3/15/2023 & ongoing-The Resident Care Director reviewed the administration records for residents to verify no other medication errors were found and required reporting to the resident, the resident's designated person and the prescriber. No additional errors identified.
3/22/2023-The Resident Care Director provided training to the Wellness Department staff on reporting to the resident, the resident's designated person and the prescriber when a medication error has been identified.
3/22/2023-The Resident Care Director or the designee report medication errors to the resident, the resident's designated person and the prescriber within 24 hours of discovery.
4/6/2023-The Executive Director or designee will discuss and review reportable incidents, including medication errors, during the morning meeting to verify they were reported timely, and the resident, the resident's designated person and the prescriber were notified.
4/7/2023 & ongoing- The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

Licensee's Proposed Overall Completion Date: *04/18/2023*

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

190c - Record of Training

32. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person C does not include the provider name, date the staff person passed, and the staff person's signature.

Plan of Correction ***Accept ([redacted] - 04/21/2023)***

4/7/2023-The community is requesting to have this violation withdrawn Staff Person C has medication administration record with documentation of provider (Sunrise Senior Living), date, staff person signature (Staff Person C). See attached Summary and Certification Initial Training.
3/15/2023-The Resident Care Director conducted an audit of all medication administration training documents for the first quarter of 2023 to verify completion.

190c - Record of Training (continued)

4/7//2023 & ongoing-The Resident Care Director or designee will review all initial medication administration paperwork quarterly.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective.

Licensee's Proposed Overall Completion Date: *04/18/2023*

Implemented (- 07/10/2023)

227d - Support Plan Medical/Dental

33. 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 for resident #8, dated /22, indicates the resident has a need for . The resident's support plan,dated does not document how this need will be met.

The assessment for resident #9, dated indicates the resident has a need for . The resident's support plan,dated does not document how this need will be met.

Plan of Correction ***Accept (- 04/13/2023)***

3/15/2023-The support plans for these residents were updated to reflect accurate plan.
3/15/2023 & ongoing-The Personal Care Coordinator and Reminiscence Coordinator conducted an audit of all support Plans to ensure they were accurate.
3/15/2023 & ongoing-The Personal Care Coordinator and Reminiscence Coordinator will review and update support plans weekly during the weekly interdisciplinary meeting.
4/7/2023 & three months ongoing- The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it is still effective

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented (- 07/10/2023)

227g -Support Plan Signatures

34. 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 #10 participated in the development of his/her support plan on [redacted]. However, the resident did not sign the support plan.

Resident #11 participated in the development of his/her support plan on [redacted] However, the resident did not sign the support plan.

Resident #12 participated in the development of his/her support plan on [redacted]. However, the resident did not sign the support plan.

Repeat Violation: 9/20/21 et al.

Plan of Correction ***Accept ([redacted] - 04/21/2023)***

3/15/2023-The Personal Care Coordinator and Reminiscence Coordinator reviewed all support plans to ensure signatures were obtained.
3/15/2023 & ongoing-The Executive Director will conduct random monthly audits to ensure all support plans have the proper signatures.
3/15/2023 & ongoing-The interdisciplinary team will review support plans during the weekly meeting to ensure all support plans have proper signatures.
4/7/2023 & three months ongoing-The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

Licensee's Proposed Overall Completion Date: *04/18/2023*

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

231c - Preadmission Screening

35. Requirements

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

Description of Violation

Resident #10 was admitted to the Secure Dementia Care Unit (SDCU) on 7/6/22. However, the resident's written cognitive preadmission screening was completed on 7/8/22.

Plan of Correction ***Accept (MS - 04/13/2023)***

3/15/2023-The Resident Care Director audited the cognitive screenings of all residents in the SDCU to ensure accuracy and compliance.
3/15/2023 & ongoing-The Resident Care Director will conduct audits of all cognitive screenings of new residents in the SDCU to ensure compliance monthly.
4/7/2023 & three months ongoing- The POC and monitoring results are discussed and evaluated (for up to three months) by the Executive Director and Coordinators at the monthly Quality Management (QAPI) meeting to ensure it s still effective.

231c - Preadmission Screening *(continued)*

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented [redacted] - 07/10/2023)