



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: NOVEMBER 3, 2023

[REDACTED]
Northland Heights LLC
[REDACTED]
[REDACTED]

RE: Northland Heights
4859 McKnight Road
Pittsburgh, Pennsylvania 15237
License/COC #: 450842

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 25, 2023, August 9, 2023, and August 15, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), mistreatment or abuse of a resident being cared for in the facility, failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 450841) dated July 24, 2023 – January 24, 2024, and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from November 3, 2023 to May 3, 2024.

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

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.


55 Pa. Code Chapter 2800 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
15(a)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
15(b)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
42(b)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
51	II	40	\$5	\$200	5 calendar days from mailing date of this letter
65(g)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
231(c)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
23(a)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
25(b)	III	40	\$3	\$120	15 calendar days from mailing date of this letter
41(e)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
141(a)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
141(b)(1)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
183(d)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
184(a)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
187(d)	II	40	\$5	\$200	5 calendar days from mailing date of this letter
191	II	40	\$5	\$200	5 calendar days from mailing date of this letter

231(d) II 40 \$5 \$200 5 calendar days from
mailing date of this letter

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

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

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:


Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[Redacted]

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

Facility Information

Name: *NORTHLAND HEIGHTS* License #: *45084* License Expiration: *02/04/2024*
Address: *4859 MCKNIGHT ROAD, PITTSBURGH, PA 15237*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *NORTHLAND HEIGHTS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *58* Waking Staff: *44*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Incident* Exit Conference Date: *07/25/2023*

Inspection Dates and Department Representative

07/25/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *123* Residents Served: *40*

Special Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *19* Residents Served: *7*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *39*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *18* Have Physical Disability: *1*

Inspections / Reviews

07/25/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/17/2023*

Inspections / Reviews *(continued)*

08/17/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 09/04/2023
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/24/2023

08/28/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: 09/04/2023
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 09/04/2023

10/02/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: 09/04/2023
Reviewer: [REDACTED] Follow-Up Type: Exception

15a Resident abuse report

1. Requirements

2800.

15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 7/11/23 at approximately 9:40 a.m., resident #1 was brought to █ newly assigned room on the second floor memory care unit. Staff persons A and B began unpacking resident #1's belongings and showing █ around her new room when staff person C started making comments to the resident that "you're not gonna be doing the stuff you did on the other floor." When staff persons A and B returned from getting a few of resident #1's toiletries from the sixth floor in order to shower the resident, they heard a commotion in resident #1's room. Resident was yelling and staff person C was heard saying, "You're not gonna talk to me like that you fuckin' b █ This ain't what you thought it was gonna be. Now you're down here on my territory." Resident #1 was asking staff person C to leave █ alone. As staff person A and B tried to calm down the resident, staff person C kept fueling the resident's agitation by saying "you're not gonna calm down ..." Staff person C refused to leave the room when staff person B suggested she step out. Staff person A took resident into the bathroom and had resident sitting on toilet. While staff person A went and got the resident's clothes out, staff person C went into the bathroom and proceeded to roughly pull the resident's top off from up █ back. Resident #1 was standing and holding onto a towel bar with the arm that was out of █ shirt and fighting not to have the second arm taken out of her shirt. Staff person C then caused resident #1 to fall between the toilet and the wall-mounted raisable grab bar. Staff person C then said, "Now you can get your fat pig a █ up off the ground. If you can █ng eat, you can get yourself up." While staff person A helped the resident up and got █ shirt back on, █ told staff person C that █ really needed to leave now. Staff person C proceeded to say "█ stinks. █ needs to be washed." Staff person A instructed staff person C that staff person A is the med tech on the floor and will decide when the resident gets a shower. All three staff persons left the room "for a breather" and staff persons A and B went back to the sixth floor to get additional belongings of resident #1 while staff person C remained on the memory care unit. When staff persons A and B returned to the memory care unit, staff person C had resident #1 in the shower. The resident was yelling at staff person C and staff person C was yelling at the resident and spraying the resident with the handheld shower stating "nobody is gonna be on my floor that stinks!"

Repeat violation 8/11/22 et al.

Plan of Correction

Directed █ 08/28/2023)

All staff, including management, will be re-educated on immediately reporting suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and complying with the requirements regarding restrictions on staff persons by Administrator by 8/31/23. A call was placed to the Area Agency on Aging (AAA) on 8/22/23 with a follow up call on 8/24/23. The AAA has agreed to provide training for all staff. Date is pending AAA availability.

Administrator will report all allegations of abuse immediately to AAA as well as to the Department of Human Services. If a report is filed by a mandated reporter and or the Administrator, the Administrator will review information for accuracy and will immediately suspend the accused employee pending investigation.

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit any allegations of abuse to ensure any allegation of abuse is reported in accordance with Regulation 2800.15(a). 2/28/23 █

15a Resident abuse report (continued)

Directed Completion Date: 08/31/2023

Not Implemented [REDACTED] - 10/2/23)

15b Resident abuse-superv plan

2. Requirements

2800.

15.b. If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 7/11/23 at approximately 9:40 a.m., resident #1 was brought to [REDACTED] newly assigned room on the second floor memory care unit. Staff persons A and B began unpacking resident #1's belongings and showing [REDACTED] around [REDACTED] new room when staff person C started making comments to the resident that "you're not gonna be doing the stuff you did on the other floor." When staff persons A and B returned from getting a few of resident #1's toiletries from the sixth floor in order to shower the resident, they heard a commotion in resident #1's room. Resident was yelling and staff person C was heard saying, "You're not gonna talk to me like that you [REDACTED] in' l [REDACTED] h! This ain't what you thought it was gonna be. Now you're down here on my territory." Resident #1 was asking staff person C to leave [REDACTED] alone. As staff person A and B tried to calm down the resident, staff person C kept fueling the resident's agitation by saying "you're not gonna calm down ..." Staff person C refused to leave the room when staff person B suggested [REDACTED] step out. Staff person A took resident into the bathroom and had resident sitting on toilet. While staff person A went and got the resident's clothes out, staff person C went into the bathroom and proceeded to roughly pull the resident's top off from up [REDACTED] back. Resident #1 was standing and holding onto a towel bar with the arm that was out of [REDACTED] shirt and fighting not to have the second arm taken out of [REDACTED] shirt. Staff person C then caused resident #1 to fall between the toilet and the wall-mounted raisable grab bar. Staff person C then said, "Now you can get your fat pig [REDACTED] s up off the ground. If you can fuc [REDACTED] eat, you can get yourself up." While staff person A helped the resident up and got [REDACTED] shirt back on, [REDACTED] told staff person C that [REDACTED] really needed to leave now. Staff person C proceeded to say [REDACTED] stinks. [REDACTED] needs to be washed." Staff person A instructed staff person C that staff person A is the med tech on the floor and will decide when the resident gets a shower. All three staff persons left the room "for a breather" and staff persons A and B went back to the sixth floor to get additional belongings of resident #1 while staff person C remained on the memory care unit. When staff persons A and B returned to the memory care unit, staff person C had resident #1 in the shower. The resident was yelling at staff person C and staff person C was yelling at the resident and spraying the resident with the handheld shower stating "nobody is gonna be on my floor that stinks!"

Repeat violation 8/11/22 et al.

Plan of Correction

Directed [REDACTED] - 08/28/2023)

The abuse was reported to Administrator and Business Office Manager on 7/11/23 at ~ 3:15pm by Staff members A and B. Staff member C had already left the residence. Staff member C was called and immediately suspended by Administrator pending investigation and told not to report to work until contacted by management. Staff member C reported to work without waiting to hear from Administrator. Staff member C was terminated by BOM and Maintenance Director on 7/12/23 at 8:45am and escorted off of the premises.

If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Administrator will report all allegations of abuse immediately to APS as well as to the Department of Human Services. If a report is filed by a mandated reporter and or the Administrator, the Administrator will review information for accuracy and will immediately suspend the accused employee pending investigation.

15b Resident abuse-superv plan (continued)

All staff, including management, will be re-educated on resident abuse reporting by Administrator by 8/31/23. Administrator will privately interview 2 residents once a week for 3 months and 2 residents a month for 6 months thereafter to ensure the resident is not being neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way beginning 9/1/23.

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit any allegations of abuse to ensure any staff person is immediately suspended or placed on a plan of supervision pre-approved by the Department and the Area Agency on Aging in accordance with Regulation 2800.15(b). 8/28/23 [REDACTED]

Directed Completion Date: 09/01/2023

Not Implemented [REDACTED] - 10/2/23)

42b Abuse/Neglect**3. Requirements**

2800.

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

Description of Violation

On 7/11/23 at approximately 9:40 a.m., resident #1 was brought to [REDACTED] newly assigned room on the second floor memory care unit. Staff persons A and B began unpacking resident #1's belongings and showing [REDACTED] around [REDACTED] new room when staff person C started making comments to the resident that "you're not gonna be doing the stuff you did on the other floor." When staff persons A and B returned from getting a few of resident #1's toiletries from the sixth floor in order to shower the resident, they heard a commotion in resident #1's room. Resident was yelling and staff person C was heard saying, "You're not gonna talk to me like that you [REDACTED] in' [REDACTED] tch! This ain't what you thought it was gonna be. Now you're down here on my territory." Resident #1 was asking staff person C to leave [REDACTED] alone. As staff person A and B tried to calm down the resident, staff person C kept fueling the resident's agitation by saying "you're not gonna calm down ...". Staff person C refused to leave the room when staff person B suggested [REDACTED] step out. Staff person A took resident into the bathroom and had resident sitting on toilet. While staff person A went and got the resident's clothes out, staff person C went into the bathroom and proceeded to roughly pull the resident's top off from up [REDACTED] back. Resident #1 was standing and holding onto a towel bar with the arm that was out of [REDACTED] shirt and fighting not to have the second arm taken out of her shirt. Staff person C then caused resident #1 to fall between the toilet and the wall-mounted raisable grab bar. Staff person C then said, "Now you can get your fat pig [REDACTED] s up off the ground. If you can [REDACTED] ng eat, you can get yourself up." While staff person A helped the resident up and got [REDACTED] shirt back on, [REDACTED] told staff person C that [REDACTED] really needed to leave now. Staff person C proceeded to say "[REDACTED] stinks. [REDACTED] needs to be washed." Staff person A instructed staff person C that staff person A is the med tech on the floor and will decide when the resident gets a shower. All three staff persons left the room "for a breather" and staff persons A and B went back to the sixth floor to get additional belongings of resident #1 while staff person C remained on the memory care unit. When staff persons A and B returned to the memory care unit, staff person C had resident #1 in the shower. The resident was yelling at staff person C and staff person C was yelling at the resident and spraying the resident with the handheld shower stating "nobody is gonna be on my floor that stinks!"

Repeat violation 5/10/23 et al.

Plan of Correction

Directed ([REDACTED] 08/28/2023)

Administrator will report all allegations of abuse immediately to APS as well as to the Department of Human Services. If a report is filed by a mandated reporter and or the Administrator, the Administrator will review

42b Abuse/Neglect (continued)

information for accuracy and will immediately suspend the accused employee pending investigation. All staff, including management, will be re-educated on resident abuse reporting by Administrator by 8/30/23. A call was placed to the Area Agency on Aging (AAA) on 8/22/23 with a follow up call on 8/24/23. The AAA has agreed to provide training for all staff. Date is pending AAA availability. Administrator will privately interview 2 residents once a week for 3 months and 2 residents a month for 6 months thereafter to ensure the resident is not being neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way beginning 9/1/23.

DIRECTED

The administrator terminated direct staff person C on 7/12/23. 8/28/23 [redacted]

Directed Completion Date: 09/01/2023

Not Implemented [redacted] - 10/2/23)

51 Criminal background checks

4. Requirements

2800.

51. Criminal background checks

- a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff person C was hired on [redacted]/23. However, the home did not complete a criminal history background check for staff person C that included a Pennsylvania State Police Criminal Background Check ("PSP check") in accordance with 6 Pa.Code Chapter 15.

Repeat violation 4/4/23 et al.

Plan of Correction

Accept [redacted] - 08/28/2023)

Staff member C was terminated by BOM and Maintenance Director on [redacted] 23 at 8:45am and escorted off of the premises.

All Direct Care staff were placed through the Pennsylvania State Police Criminal Background Check by the Administrator as 8/3/23. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults). A new hire checklist has been created to include the PSP background check. Results will be obtained prior to the first day of work for all direct care staff.

Business Office Manager or Administrator will audit all new staff records within 30 days of their employment beginning 8/25/23.

Licensee's Proposed Overall Completion Date: 08/25/2023

Not Implemented [redacted] - 10/2/23)

65g Initial direct care training

5. Requirements

2800.

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

65g Initial direct care training (continued)

Description of Violation

Direct care staff person C, hired [REDACTED] 23, did not complete 18 hours of training prior to providing unsupervised assisted living services. Direct care staff person C has worked unsupervised in the residence on numerous occasions to include 7/11/23 from approximately 9:30 a.m. until 1:00 p.m. and 7/12/23 from 7:00 a.m. until approximately 9:00 a.m.

Repeat violation 4/4/23 et al.

Plan of Correction

Accept ([REDACTED] - 08/28/2023)

Staff member C was terminated on [REDACTED] 23. All current direct care staff completed the 18 hours of training by 8/4/23 to include all topics specified in 2800.65g

Direct care staff persons will not provide unsupervised assisted living services until completion of 18 hours of training specified in 2800.65g.

A new hire checklist has been implemented effective 7/31/23 to ensure all newly hired direct care staff persons complete all training requirements specified in 2800.65g. Relias learning was implemented for all staff starting 8/1/23. All staff persons involved in the hiring process were re-educated by the Administrator on 7/31/23 on the new hire checklist. The Director of Nursing will ensure that new direct care staff do not provide unsupervised assisted living services prior to the completion of the 18 hours of specified training beginning 8/1/23.

Licensee's Proposed Overall Completion Date: 08/25/2023

Not Implemented ([REDACTED] - 10/2/23)

142a Supplement health services

6. Requirements

2800.

142.a. Each residence shall demonstrate the ability to provide or arrange for the provision of supplemental health care services in a manner protective of the health, safety and well-being of its residents utilizing employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service.

Description of Violation

On 6/24/23 during morning medication pass, staff person A noticed that resident #2 was having increased coughing, gasping while coughing and trouble taking [REDACTED] medications which [REDACTED] did one by one. Staff person A had a call put out to the resident's [REDACTED] and when [REDACTED] called back, staff person A updated [REDACTED] regarding resident #2's condition. Resident's [REDACTED] replied that [REDACTED] would be visiting around 4:00 p.m. and would decide then what to do. Emergency medical services were not called until 3:50 p.m. after the LPN on the 3:00 p.m.- 11:00 p.m. shift checked on resident and was concerned about [REDACTED] well-being based on her appearance being "ghostly white." EMS arrived on-sight at approximately 4:04 p.m. According to the EMS trip report, the resident had a fever of 102.7 degrees Fahrenheit, and the "nursing staff was not aware of [REDACTED] fever and had not provided relief."

Plan of Correction

Accept ([REDACTED] 08/28/2023)

Resident #2 no longer resides at the residence as of [REDACTED]/23. The Director of Nursing will re-educate the staff on providing or arranging for the provision of supplemental health care services in a manner protective of the health, safety and well-being of the residents utilizing employees, independent contractors or contractual arrangements with other health care facilities or practitioners licensed, registered or certified to the extent required by law to provide the service. This education includes notifying the provider and Director of Nursing with a change in condition. Education will be completed by 8/31/23.

Director of Nursing will monitor for appropriate arrangement of supplemental health care services by reviewing 24

142a Supplement health services (continued)

hour reports beginning 8/25/23.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (█) 10/02/2023)

231c1 Preadmit screening

7. Requirements

2800.

231.c.1. Special care unit for residents with Alzheimer’s disease or dementia.

- i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department’s cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Description of Violation

Resident #1 was admitted to the residence’s special care unit on █/23. However, the resident’s preadmission screening was completed on 6/29/23.

Repeat violation 4/4/23 et al. 1/6/23

Plan of Correction

Accept (█) 08/28/2023)

All persons responsible for preadmission screening were re-educated by the Director of Quality Assurance on the completion of the written cognitive screening that must be done 72 hours prior to admission on a special care unit. This education was completed on 7/26/23. This education included that a written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department’s cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Administrator created and implemented a new resident admission checklist on 8/10/23 to ensure all pre-admission paperwork is in accordance with 2800.231c. All current resident charts were reviewed by Quality Assurance Nurse and Area Operations Director on 8/15/23. Administrator will monitor all new admissions in collaboration with a medical provider or geriatric assessment team to ensure preadmission screening form shall be completed for each resident within 72 hours prior to transfer to or admission to a special care unit beginning on 8/25/23.

Licensee's Proposed Overall Completion Date: 08/25/2023

Not Implemented (█) - 10/2/23)

234a Admission – support plan

8. Requirements

2800.

234.a. Support or rehabilitation plan

- 1. Within 72 hours of the admission, or within 72 hours prior to the resident’s admission to the special care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #1’s support plan was developed and signed on 7/1/23. However, the resident was not admitted to the residence’s special care unit until █23.

Plan of Correction

Directed (█) 08/28/2023)

The Director of Nursing will ensure that all support or rehabilitation plans will be completed within 72 hours of the admission or within 72 hours prior to the resident’s admission to a special care unit. A support plan shall be

234a Admission – support plan (continued)

developed, implemented, and documented in the resident records.

Administrator created a new resident admission checklist on 8/10/23. Administrator will monitor all new admissions to ensure support plan shall be completed for each resident within 72 hours of the admission, or within 72 hours prior to the resident’s admission to the special care unit, a support plan shall be developed, implemented and documented in the resident record starting on 8/25/23.

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall review resident #1’s support plan for accuracy and completeness. 8/28/23 [REDACTED]

Directed Completion Date: 08/29/2023

Not Implemented [REDACTED] - 10/2/23)

234b Support plan - elements

9. Requirements

2800.

234.b. Plan requirements.

- 1. The support plan and if applicable, the rehabilitation plan, must identify the resident’s physical, medical, social, cognitive and safety needs.

Description of Violation

Resident #1 was admitted to the residence’s special care unit on [REDACTED]/23. However, the following diagnoses and plan to meet the needs that were indicated on the resident’s ADME completed 6/29/23, were not included on the resident’s support plan signed 7/1/23: anemia, hypertension, hyperlipidemia, Type II diabetes mellites, and major depressive disorder.

Plan of Correction

Accept [REDACTED] 08/28/2023)

Director of Nursing updated resident #1 support plan to include all diagnoses listed on the ADME on 7/26/23.

Audits for compliance to ensure the support plan and if applicable, the rehabilitation plan, identifies the resident’s physical, medical, social, cognitive and safety needs. will be conducted by the Director of Nursing quarterly or with a significant change in resident condition beginning 8/25/23.

Licensee's Proposed Overall Completion Date: 08/25/2023

Not Implemented [REDACTED] - 10/2/23)