Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

August 8, 2023

, PRESIDENT
BERWYN REAL ESTATE LP

RE: DAYLESFORD CROSSING
1450 EAST LANCASTER AVENUE
PAOLI, PA, 19301
LICENSE/COC#: 14154

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/22/2023, 05/23/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *DAYLESFORD CROSSING* **Licen e #**: *14154* **Licen e Expiration**: *07/20/2023*

Address: *1450 EAST LANCASTER AVENUE, PAOLI, PA 19301*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Phone **Email**:

Certificate(s) of Occupancy

Type: *C 1* **Date**: *08/05/2015* **I ued By**: *Tredyffrin Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *126* **Waking Staff**: *95*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date**: *05/23/2023*

Inspection Dates and Department Representative

05/22/2023 On Site

05/23/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *80*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *24* **Residents Served**: *17*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *80*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *46* **Have Physical Disability**: *0*

Inspections / Reviews

05/22/2023 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/15/2023*

06/20/2023 - POC Submission

Submitted By **Date Submitted**: *07/19/2023*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/25/2023*

Inspections / Reviews *(continued)*

06/22/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/19/2023*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *07/22/2023*

08/08/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *07/19/2023*
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 did not receive prescribed medications several times in April 2023. None of the medication errors were reported to the department.

Resident 2 is prescribed Insulin , call MD for under 70 or over 400 subcutaneously three times a day. On /23, only 2 readings were taken. And on /23 at PM the reading was 202 which translates to 2 units. However this was not documented, and no insulin was given. These medication errors were not reported to the department.

Resident 3 is prescribed take 1 tablet by mouth every 12 hours. The Blister pack is 0.25mg. 2 pills should be given to total 0.5mg, however only 1 pill was given at every administration from 5/12/23 to 5/22/23. These medication errors were not reported to the department.

Plan of Correction ***Accept (- 06/22/2023)***

t was identified on 5/23/23 that medication errors had occurred that had not been reported to the Department. On 5/25/23 all Nurses were re-educated by the Health & Wellness Director on the requirements of regulation 2600.16(c) to ensure that all medications errors were accurately reported to the Department within 24 hours. The HWD, and/or designee, will audit incidents daily for two weeks, beginning on 5/25/23, then weekly for three months, to ensure reportable incidents are reported to the Department within 24 hours. The HWD is responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented - 08/08/2023)

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

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

Plan of Correction ***Accept - 06/20/2023)***

t was identified that Staff Member A's educational background was completed outside of the United Sates without the applicable waiver on file from the Department. Upon this discovery, a re-education training was provided by the Executive Director with the Business Office Manager on 5/24/23 reviewing the requirements of Regulation

54a - Direct Care Staff (continued)

2600.54(a). Additionally, the waiver request was submitted to the Department on 5/22/23. The Department responded requesting 3 years of transcripts to approve the Waiver, so Staff Member A is in contact with her school to obtain necessary documentation. Moreover, the Business Office Manager completed an audit on 5/24/23 of all current employee files to ensure the requirements of Regulation 2600.54(a) had been met, and there were no additional findings out of compliance in that audit. Ongoing compliance with this regulation is the responsibility of the Business Office Manager, who will complete quarterly audits for two quarters.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented ██ - 08/08/2023)

65a FS Orientation 1st Day

3. 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:

Description of Violation

Staff person A, whose first day of work was ██/23, did not receive 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.
(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 ██ - 06/22/2023)***

On 6/21/23, a training was completed by the Executive Director, with the Business Office Manager, to ensure that prior to or during the first work day, all direct care staff persons including ancillary staff persons shall have an orientation in general fire safety and emergency preparedness that includes (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, (5) the location and use of fire extinguishers, (6) Smoke detectors and fire alarms, (7) Telephone use and notification of emergency services). The Business Office Manager audited all employee files on 5/24/23 and found no other employees to be out of compliance. Beginning 5/29/23 the Business Office Manage or designee will audit all new associate files for compliance of regulation 2600.65(a) and ongoing weekly audits for the next two months will be completed. The Business Office Manager is responsible for ongoing compliance with this regulation.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented ██ - 08/08/2023)

65b Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff person A began was hired on /23. However, this staff person did not complete training in the following topics:

(1) Resident rights.

(2) Emergency medical plan.

(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act

(35 P.S. § 10225.101-10225.5102).

(4) Reporting of reportable incidents and conditions.

Plan of Correction ***Accept - 06/22/2023)***

On 6/21/23, a training was completed by the Executive Director, with the Business Office Manager, to ensure that prior to or during the first 40 scheduled working hours, all direct care staff persons including ancillary staff persons shall have an orientation in general fire safety and emergency preparedness that includes (1) Resident Rights, (2) Emergency Medical Plan, (3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, 4) Reporting of reportable incidents and conditions. The Business Office Manager audited all employee files on 5/24/23 and found no other employees to be out of compliance. Beginning 5/29/23 the Business Office Manage or designee will audit all new associate files for compliance of regulation 2600.65(b) and ongoing weekly audits for the next two months will be completed. The Business Office Manager is responsible for ongoing compliance with this regulation.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented - 08/08/2023)

65f - Training Topics

5. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
5. Personal care service needs of the resident.

Description of Violation

Direct care staff person B did not receive training in personal care service needs during training year 2022.

Plan of Correction ***Accept (- 06/22/2023)***

Upon discovery that Staff Person B had not completed the required Personal Care Services Needs of the Resident training, a re-education on this training was completed by the Health & Wellness Director on 5/24/23 with Staff Person B. To ensure ongoing compliance, the Business Office Manager was retrained on this regulation's requirements on 5/24/23, and The Business Office Manager will audit 10% of current employee training files to ensure that the following criteria are met: (1) Medication self-administration training. (2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. (3) Care for residents with dementia and cognitive impairments. (4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, ncontinence, malnutrition and dehydration. (5) Personal care service needs of the resident. (6) Safe management techniques. (7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home. This audit will be completed by 6/30/23. If any additional training records are found to be out of

65f - Training Topics (continued)

compliance, an audit of all associates will be completed by 7/31/23 by the Business Office Manager. Effective 6/21/23 and until 12/31/23, the Business Office Manager will audit all associate training files monthly, prior to monthly Town Hall training meetings, and notify the appropriate Department Head of any associates who have missing training, if applicable. All training will be completed by the end of calendar year per regulation for all current associates. Ongoing compliance with regulation 2600.65(f) is the responsibility of the Business Office Manager and Department Heads.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented (- 08/08/2023)

65i - Training Record

6. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training does not include the date dementia training was completed for staff person B and the content of the training.

Plan of Correction ***Accept (- 06/22/2023)***

The required 6 hour Dementia Training sign in sheet, reflecting Staff Person B's attendance, dated 11/16/22, trained by (Vice President of Operations), including the content and agenda of the training, was accepted and reviewed by the Surveyor upon request. However, Surveyor stated that the Dementia training agenda and course content packet were not attached to the sign-in sheet; therefore, it was not accepted. Additionally, when the Surveyor asked us for documentation of the date the training was completed on, we indicated that it was listed on the training sign-in sheet (11/16/22).
The Business Office Manager was retrained on 5/24/23 on the contents of regulation 65(i) to ensure that a record of training include the staff person trained, date, source, content, length of each course and copies of any certificates received shall be kept. Effective 6/21/23 and until 12/31/23, the Business Office Manager will audit all associate training files monthly, prior to monthly Town Hall training meetings to ensure that the date, source, content, and engthof each training course is recorded. All training will be completed by the end of calendar year per regulation for all current associates. Additionally going forward, to simplify this process, effective 6/1/23 we have updated our Training Record document to list the anticipated and actual dates separately on each associate's annual Training Record. Ongoing compliance with this regulation is the responsibility of the Business Office Manager.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented (- 08/08/2023)

85e - Trash Outside Home

7. Requirements

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

Description of Violation

On 5/22/23, at 10:34 am, the home's dumpster was not covered.

85e - Trash Outside Home *(continued)*

Plan of Correction ***Accept (█ - 06/20/2023)***

Upon discovery that the dumpster lid was open during the time of review, the dumpster lid was closed immediately. A re-education was completed by the Executive Director on 5/24/23 with all associates on the contents of regulation 2600.85(e) to ensure all staff were aware that the dumpster lid must remain closed. Additionally, a daily audit is being completed and documented by the Building Engineer until 8/31/23. Ongoing compliance with this regulation is the responsibility of the Building Engineer.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (█ - 08/08/2023)

121a - Unobstructed Egress

8. Requirements

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

Description of Violation

On 5/23/23 at 10:40 am, the exit from the courtyard to the courtyard stairwell was blocked by 2 chairs.

Plan of Correction ***Accept (█ - 06/20/2023)***

Upon discovery that 2 resident patio chairs in our memory care courtyard were blocking egress to an emergency exit on 5/23/23, the chairs were moved immediately. Also, on 5/23/23, The Building Engineer immediately checked all other emergency exits throughout the community and found no additional obstructions. A re-education was completed by the Executive Director on 5/24/23 with all associates to ensure all staff understood the contents of regulation 2600.121(a). Also, signage was purchased and hung at the entrance and exit of the memory care courtyard as a reminder to residents and staff to keep exits clear for safe egress. Additionally, a daily audit is being completed and documented by the Building Engineer until 8/31/23 to ensure there are no areas or exits obstructed. Ongoing compliance with this regulation is the responsibility of the Building Engineer.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (█ - 08/08/2023)

141a - Medical Evaluation

9. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident 2 did not have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department.

Plan of Correction ***Accept (█ - 06/20/2023)***

Upon discovery that Resident 2's medical evaluation had not been accurately signed, the medical evaluation was immediately faxed by the Health & Wellness Director to the Medical Provider for signature. This was received back and signed on 5/26/23. A re-education was completed on 5/26/23 by the Health & Wellness Director with the Nursing staff and Move-In Coordinator on the contents of this regulation. An audit was completed by the Health &

141a - Medical Evaluation (continued)

Wellness Director by 5/31/23 of all current residents. Any additional discrepancies were corrected. To ensure ongoing compliance, any new admissions or any residents with significant change of condition will be reviewed for accurate signatures on the Medical Evaluation Form by the Health & Wellness Director upon admission or upon a resident's significant change of condition. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

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

Implemented [redacted] - 08/08/2023)

162c - Menus Posted

10. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 5/22/23, a 2-week menu was not posted in the home.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

Upon discovery that we were only posting our dining menus for the current week, we immediately posted the following week in advance's menu selection in both our Personal Care and Memory Care dining rooms. A re-education was completed by the Executive Director on 6/6/23 with the Dining Services Director as well as with the Memory Care Director to ensure the current menu and week in-advance menu were posted in both locations weekly. Weekly, beginning 6/19/23 the Dining Director will post two weeks of upcoming menus in both the Personal Care and Memory Care dining rooms. Effective 6/26/23, the Executive Director will audit weekly, for the next two months, to ensure that the two week dining menus are posted accurately in both dining rooms Ongoing compliance with this regulation is the responsibility of the Dining Services Director.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented [redacted] - 08/08/2023)

182b - Prescription Medication

11. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Description of Violation

On [redacted]/23 at [redacted] pm staff person B administered medications to residents to include the following; [redacted] [redacted] Staff person B is not one of the following:
(1) A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
(4) A staff person who has completed the medication administration training as specified in § 2600.190 for the

182b - Prescription Medication (continued)

administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept 06/22/2023)***

t was identified on 5/23/23 that Staff person B's Medication Technician certification was out of compliance mmediately, Staff person B was removed from the Medication Administration role and was reassigned to provide direct care to our residents. On 5/24/23 Staff person B was re-certified as a Medication Technician by a certified Medication Train the Trainer. All current Med Tech certifications will be audited for ongoing compliance by the Health & Wellness to be completed by 6/30/23. The Health & Wellness Director will audit all Medication Technician Certificates, monthly, beginning 7/1/23, to ensure compliance with regulation 2600.182(b) for the next three months. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented - 08/08/2023)

184a - Resident's Meds Labeled

12. Requirements

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

Description of Violation

Resident 4 is prescribed insert 1 suppository rectally every 4 hours as needed. However, the medication label reads insert every 6 hours as needed.

Resident 4 is prescribed every 6 hours as needed. However, the medication label reads 1 or 2 teaspoonful every 6 hours as needed.

Resident 4 is prescribed by mouth daily. However, the medication label reads take 7.5ml every day.

Plan of Correction ***Accept (- 06/22/2023)***

Upon discovery that Resident 4's medications were incorrectly labeled, change of direction stickers were immediately applied on 5/23/23 to medication containers by the Health & Wellness Director, correlating directly to the prescriber's order as listed in the MAR. A re-education was completed on 5/28/23 and 6/2/23 by the Health & Wellness Director with all Nurses and Med Techs to ensure medication labels directly correspond with physician orders in the MAR. A complete medication cart audit for each medication cart will be completed by 6/30/23 by the Health & Wellness Director to ensure labels accurately match physician orders. Beginning 7/1/23 a complete a medication cart audit for each medication cart will be completed weekly for the next two months by the Health & Wellness Director to ensure compliance. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

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

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented [redacted] - 08/08/2023)

185a - Implement Storage Procedures

13. 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

On [redacted]/23 at [redacted] pm. [redacted] was administered to Resident 1 and was not signed out on the controlled substance log.

The glucose reading for resident 2 on [redacted]/23 at [redacted] am is documented as [redacted]. However, there is no corresponding reading on the residents glucometer at that time.

On [redacted]23 at [redacted] pm the glucometer reading for resident 2 was [redacted] but was not documented.

Plan of Correction ***Accept ([redacted] - 06/20/2023)***

Upon discovery that Resident 1 had a medication administered but not signed out on the controlled substance log, and that the glucose reading for Resident 2 was documented in the MAR but did not have a corresponding reading in the glucometer, and inversely, Resident 2 had a glucose reading in the glucometer that was not documented in the MAR, all Nurses and Med Techs were re-educated by the Health & Wellness Director on 6/2/23 regarding accurate documentation of medications and blood sugar readings in the Medical Record. The Narcotic Log will be compared to the MAR for accurate documentation one time per week for two weeks, beginning 6/12/23, by the Health & Wellness Director to ensure all medications are signed out per regulation. Also, the Glucose Monitor readings will be compared to the documented results in the MAR to ensure that they match, beginning 6/12/23. This will be completed by the Health & Wellness Director daily for two weeks. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

Licensee's Proposed Overall Completion Date: *06/26/2023*

Implemented [redacted] - 08/08/2023)

187c - Refusal of Medication

14. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

187c - Refusal of Medication *(continued)*

Description of Violation

Resident 1 refused to take scheduled medications several times in [redacted] 2023. The home did not report the refusals to the prescriber.

Plan of Correction ***Accept ([redacted] - 06/20/2023)***

Resident 1 was alert, oriented, and refusing Hospice pain medication on the days she was feeling well. The Health & Wellness Director, as well as staff Nurses, had reported these refusals to both the resident's Power of Attorney and Prescriber as documented in the Resident's progress notes. The Prescriber and Power of Attorney stated that the resident is able to refuse medication as she saw fit, and that they did not need to be notified by the Nursing staff each and every time that Resident 1 refused. Per regulation, the Health & Wellness Director has created a "Notification of Medication Refusal Form" to make the Prescriber aware of the refusal and for the Prescriber to indicate how often he or she would like to be notified of the resident's refusal of medication, if ongoing. Resident 1 has since passed away, and no other residents in the Home are currently refusing medications routinely; however, moving forward, if a resident is regularly refusing medication, the Health & Wellness Director or designee will obtain written documentation from the prescriber on the created "Notification of Medication Refusal Form" indicating how frequent they would like to be notified of the medication refusal. This signed form will be placed in the residents' medical record. A training was provided by the Health & Wellness Director on 6/8/23 with all Nurses on when/how to use this form. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

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

Implemented ([redacted] - 08/08/2023)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident 1 is prescribed [redacted] give 0.25 ml by mouth every 6 hours. However, resident 1 was not administered this medication on several dates which include [redacted]/23 at [redacted] [redacted]/23 at [redacted], and [redacted] at [redacted] am.

Resident 2 is prescribed [redacted]: [redacted]
[redacted]
subcutaneously three times a day. On [redacted] 23, only 2 readings were taken. And on [redacted]/23 at [redacted] PM the reading was [redacted] which translates to [redacted] units. However this was not documented, and no insulin was given.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

Resident 1 was prescribed medication which was not administered on several dates in [redacted] due to Resident 1's refusal. Resident 2 was prescribed insulin which was not administered. Resident 3 was prescribed and administered a medication daily. However, the medication for Resident 3 was not available in the home when the Surveyor audited the medication cart during the afternoon of 5/23/23, after Resident 3 had already received that medication the morning of 5/23/23 as prescribed. In addition, the pharmacy had already been notified to deliver said medication

187d - Follow Prescriber's Orders (continued)

during the evening delivery of 5/23/23. A re-education was provided by the Health & Wellness Director on 6/8/23 regarding compliance with medication administration and documentation, including timely reordering of medications. Beginning 6/5/23, the Health & Wellness Director will audit 10 random resident's MARs once per week for the next two weeks, and then every two weeks for the next two months, to ensure medication is signed off as ordered by the Primary Care Physician. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented (- 08/08/2023)

16. Requirements

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

Description of Violation

Resident 3 is prescribed tab take 1 tablet by mouth daily. However, this medication was not available in the home on 5/23/23.

Plan of Correction ***Accept (- 06/22/2023)***

Resident 1 was prescribed medication which was not administered on several dates in due to Resident 1's refusal. Resident 2 was prescribed insulin which was not administered. Resident 3 was prescribed and administered a medication daily. However, the medication for Resident 3 was not available in the home when the Surveyor audited the medication cart during the afternoon of 5/23/23, after Resident 3 had already received that medication the morning of 5/23/23 as prescribed. In addition, the pharmacy had already been notified to deliver said medication during the evening delivery of 5/23/23. A re-education was provided by the Health & Wellness Director on 6/8/23 regarding compliance with medication administration and documentation, including timely reordering of medications. Beginning 6/5/23, the Health & Wellness Director will audit 10 random resident's MARs once per week for the next two weeks, and then every two weeks for the next three months, to ensure medication is signed off as ordered by the Primary Care Physician. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

Licensee's Proposed Overall Completion Date: *09/30/2023*

Implemented (- 08/08/2023)

188b - Medication Error Reporting

17. 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 did not receive prescribed medications several times in . None of the medication errors were reported to the resident, the resident's designated person and the prescriber.

Resident 2 is prescribed Insulin On /23, only 2 readings were taken. And on /23 at PM the reading was which translates to 2 units. However this was not documented, and no insulin was given. These medication errors

188b - Medication Error Reporting (continued)

were not reported to the resident, the resident's designated person and the prescriber.

Resident 3 is prescribed [redacted] take 1 tablet by mouth every 12 hours. The Blister pack is 0.25mg. 2 pills should be given to total 0.5mg, however only 1 pill was given at every administration from 5/12/23 to 5/22/23. These medication errors were not reported to the resident, the resident's designated person and the prescriber.

Resident 3 is prescribed [redacted] take 1 tablet by mouth every 12 hours. The Blister pack is 0.25mg. 2 pills should be given to total 0.5mg, however only 1 pill was given at every administration from 5/12/23 to 5/22/23.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

Upon discovery that there were medication errors that had not been properly reported to the prescriber and designated person, a re-education was completed by the Health & Wellness Director, with all Nurses and Med Techs, on 6/5/23 to inform them that all medication errors including the following must be reported to the resident's designated person and prescriber, including a documented reason in the Medical Record:
• Failure to administer a medication. • Administration of the wrong medication. • Administration of the wrong amount of medication. • Failure to administer a medication at the prescribed time. • Administration to the wrong resident. • Administration through the wrong route.
The Heath & Wellness Director will review any medication errors within 24 hours to ensure that the error was immediately reported to the resident, the resident's designated person and the prescriber, beginning 6/21/23. Documentation will be kept in the resident record and the Department of Human Services Reportable Incident Binder within 24 hours of the error. The Health & Wellness Director will audit for medication errors daily for two weeks beginning on 6/21/23 and then weekly for the next two months. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented ([redacted] - 08/08/2023)

190a - Completion Medication Course

18. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
On [redacted]/23 at [redacted] pm, [redacted] was administered to resident 1.
On [redacted]/23 at [redacted] am, [redacted] was administered to resident 3.

Plan of Correction ***Accept [redacted] - 06/22/2023)***

It was identified on 5/23/23 that Staff person B's Medication Technician certification was out of compliance. Immediately, Staff person B was removed from the Medication Administration role and was reassigned to provide direct care to our residents. On 5/24/23 Staff person B was re-certified as a Medication Technician by a certified

190a - Completion Medication Course (continued)

Medication Train the Trainer. All current Med Tech certifications will be audited (see audit referenced in POC of regulation 2600.182(b)) for ongoing compliance by the Health & Wellness Director and Medication Train the Trainer to be completed by 6/30/23. The Health & Wellness Director will audit all Medication Technician Certificates, monthly, beginning 7/1/23, to ensure compliance with regulation 2600.190(a) for the next three months. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented ██ - 08/08/2023)

190b - Insulin Injections

19. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 5/15/23 at 12:00 pm, staff person B, who has not successfully completed a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program, administered insulin to resident 2.

Plan of Correction ***Accept ██ - 06/22/2023)***

Despite Staff Person B's diabetic administration certification being in compliance, it was identified on 5/23/23 that Staff person B's Medication Technician certification was out of compliance. Immediately, Staff person B was removed from the Medication Administration role and was reassigned to provide direct care to our residents. On 5/24/23 Staff person B was re-certified as a Medication Technician by a certified Medication Train the Trainer. All current Med Tech certifications will be audited (see audit referenced in POC of regulation 2600.182(b)) for ongoing compliance by the Health & Wellness Director and Medication Train the Trainer to be completed by 6/30/23. The Health & Wellness Director will audit all Medication Technician Certificates, monthly, beginning 7/1/23, to ensure compliance with regulation 2600.190(b) for the next three months. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented ██ - 08/08/2023)

224a - Preadmission Screen Form

20. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 5's preadmission screening form, dated ██ does not include a determination that the needs of the resident can be met by the services provided by the home.

224a - Preadmission Screen Form *(continued)*

Plan of Correction ***Accept (MS 06/20/2023)***

Upon discovery that Resident 5's preadmission screening form, dated [redacted], did not include a determination that the needs of the resident can be met by the services provided by the home, the form was corrected on 5/23/23 by the Health & Wellness director, indicating that we could meet the needs of the resident met by the services provided by the home. All current resident pre-admission screening forms were audited by the Health & Wellness Director on 5/31/23 to confirm there were no additional residents with incomplete pre-admission screening forms. A re-education was completed by the Health & Wellness Director on 5/26/23 with the Nurses and Move-In Coordinator to review accurate completion of the pre-admission screening form. To ensure ongoing compliance, the Health & Wellness Director will review all pre-admission screening forms for all new move-ins ongoingly to ensure accuracy of completion.

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

Implemented ([redacted] - 08/08/2023)

225a - Assessment 15 Days

21. Requirements

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

Description of Violation

Resident 2's assessment, dated [redacted], does not include an assessment for understanding instructions.

Plan of Correction ***Accept [redacted] 06/20/2023)***

Upon discovery that Resident 2's initial assessment did not indicate whether Resident 2 could understand instructions, the Health & Wellness Director updated the assessment to indicate that Resident 2 was able to understand instructions on 5/23/23. All current resident initial assessments were audited by the Health & Wellness Director on 5/31/23 to confirm there were no additional residents with an incomplete initial assessment. A re-education was completed by the Health & Wellness Director on 5/26/23 with the Nursing staff to ensure that all sections of an initial assessment are complete and accurate. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

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

Implemented [redacted] - 08/08/2023)

225c - Additional Assessment

22. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident 3's assessment, dated [redacted] does not mention the resident's history of suicide attempt or ideations.

225c - Additional Assessment *(continued)*

Plan of Correction ***Accept [redacted] - 06/20/2023)***

Upon discovery that an updated assessment for a significant change of condition was not completed for Resident 3 post hospitalization from having suicidal ideations, immediately the Health & Wellness Director updated Resident 3's assessment on 5/23/23 to reflect the resident's suicide attempt, ideations, and recent hospital stay. A re-education was completed by the Health & Wellness Director on 5/23/23 with all Nurses to reemphasize the need for a new assessment once a significant change of condition is identified. All resident records were audited by the Health & Wellness Director on 5/31/23 with no other significant change assessments being identified. Ongoing compliance with this regulation is the responsibility of the Health & Wellness Director.

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

Implemented [redacted] - 08/08/2023)

233c - Key-Locking Devices

23. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to the courtyard exit in the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept [redacted] - 06/22/2023)***

Upon discovery that there were exit doors that did not have the directions for operation conspicuously posted near the locking device, immediately on 5/23/23 the Executive Director posted accurate instructions, with each exit door key code, next to each locking door. The Executive Director checked each exit and verified that with these added postings, all doors had accurate instructions on how to unlock exit doors. Effective 6/26/23, the Executive Director will audit weekly, for the next two months, to ensure that the instructions for operating any exit doors are posted conspicuously near the device. Ongoing compliance with this regulation is the responsibility of the Executive Director.

Licensee's Proposed Overall Completion Date: *07/20/2023*

Implemented ([redacted] - 08/08/2023)