pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **HERSHEY OPERATIONS LLC**
LEGAL ENTITY

To operate **HARMONY AT HERSHEY**
NAME OF FACILITY OR AGENCY

Located at **75 EAST CANAL STREET, HERSHEY, PA 17033**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **129** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 39**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 21,** **2023** until **June 21,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **337411**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: DECEMBER 21, 2023

[redacted], Administrator
Hershey Operations LLC
[redacted]

RE: Harmony at Hershey
75 East Canal Street
Hershey, Pennsylvania 17033
License #: 337411

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on August 8-10, 2023 and November 7-9, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (337410) dated June 14, 2023 to June 14, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST 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) and 55 Pa. Code §20.71(a)(2);(4);(5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (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 2600:	Class of Violation	Census at Inspection	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
2600.16(c)	II	74	$5	$370	5 calendar days from mailing date of this letter
81(b)	II	74	$5	$370	5 calendar days from mailing date of this letter
85(a)	II	74	$5	$370	5 calendar days from mailing date of this letter
187(a)	II	74	$5	$370	5 calendar days from mailing date of this letter
187(d)	II	74	$5	$370	5 calendar days from mailing date of this letter
224(a)	II	74	$5	$370	5 calendar days from mailing date of this letter
254(a)	III	74	$5	$370	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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted] Fetzer
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

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

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure

Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

Name: *HARMONY AT HERSHEY* **License #:** *33741* **License Expiration:** *06/14/2024*

Address: *75 EAST CANAL STREET, HERSHEY, PA 17033*

County: *DAUPHIN* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *HERSHEY OPERATIONS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *04/02/2021* **Issued By:** *Labor and Industry*

Type: *I-2* **Date:** *04/02/2021* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *114* **Waking Staff:** *86*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *08/10/2023*

Inspection Dates and Department Representative

08/08/2023 - On-Site: [redacted]
08/09/2023 - On-Site: [redacted]
08/10/2023 - On-Site: [redacted]
08/11/2023 - Off-Site: [redacted]
08/14/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *129* **Residents Served:** *79*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Harmony Square* **Capacity:** *39* **Residents Served:** *31*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *79*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *35*
Have Physical Disability: *0*

Inspections / Reviews

08/08/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/01/2023*

09/12/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/15/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/19/2023*

10/03/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/15/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/01/2023*

12/11/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *11/15/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

3c - Post Current License

1. Requirements

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

Description of Violation

On 8/8/23, the home's licensing inspection summaries from 9/27/22, 12/6/22, 2/6/23, and 4/10/23, were not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.3c Post Current License:
All Licensing Inspection Summaries have been posted in both areas assessed by the inspector at the building. See Appendix A

(Directed)
As of 9/15/23, the current Licensing Inspection Summaries (LISs) have been posted by the Administrator. By 11/1/23, the administrator or designee will check weekly for 3 months to ensure that the LISs are in place. The checks will be documented and include the name of the person verifying the LISs are posted and the date that the check is completed. These check lists will be kept by the home for inspection by the Department.

Directed Completion Date: *11/01/2023*

3c - Post Current License *(continued)*

Implemented [redacted] 12/11/2023)

16c - Written Incident Report

2. 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

As of 8/8/23, the following medication errors were not reported to the Department:

On 8/1/23 at 10:00 AM, Resident 1 did not receive prescribed Escitalopram 10 MG, Levothyroxine 75 MCG, Losartan Potassium 50 MG, Metoprolol Succ ER 50 MG, or Omeprazole DR 20 MG.

On 8/5/23, Residents 2 and 3 did not receive prescribed Lidocaine patches as ordered by the physician.

Resident 4 was prescribed Metolazone 2.5 mg tablet on 8/4/23. On the morning of 8/9/23, two tablets remained in the pack when the medications should have been out by 8/7/23.

Repeated violation - 3/29/23, 2/6/23, 9/27/22, et al

Plan of Correction ***Directed [redacted] 09/22/2023)***

2600.16c. Written Incident Report:
All Leadership In serviced on the reporting process of a reportable incident. See Appendix B

(Directed)
By 11/1/23, the administrator or designee will conduct training of all staff on reportable incidents and conditions. Specific training targeted at medication technicians will also be conducted to review what a medication error is, how to identify a medication error, and the steps to report it. This training will be documented. Moving forward, the administrator will hold a quality management review no later than 11/1/23 to review and discuss reportable incidents and conditions that have occurred.

16c - Written Incident Report (continued)

Directed Completion Date: *11/01/2023*

Not Implemented [redacted] - 12/11/2023)

18 - Compliance With Laws

3. Requirements

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

Description of Violation

On 8/8/2023, the home did not have the required flu vaccination information posted in a public and conspicuous place.

The home does not permit smoking on the premises. On 8/8/23, there are no signs on the entrances of the home indicating no smoking or smoking permitted in designated areas. Per the clean indoor air act, personal care homes must post a sign at each entrance that states "Smoking Permitted in Designated Areas Only" or "No Smoking."

Plan of Correction ***Directed ([redacted] - 09/22/2023)***

(Directed)
2600.18 Compliance with Laws:
As of 9/15/23, a no-smoking sign has been posted at the front of the building. Beginning 11/1/23, the administrator or designee will conduct and document weekly checks for two months to ensure that the no-smoking sign remains in place.

As of 9/15/23, the influenza awareness poster has been posted in a conspicuous and public place at the entrance. Beginning 11/1/23, the administrator or designee will conduct and document weekly checks for two months to ensure that the influenza awareness poster remains in place.

18 - Compliance With Laws (continued)

Directed Completion Date: *11/01/2023*

Implemented [redacted] - 12/11/2023)

42b - Abuse

4. Requirements

2600.
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

Resident 4 received an order on 8/4/23 for Zaroxolyn, 2.5 MG - take 1 tablet by mouth 2 times a day at 8:30 AM for 3 days. The medication administration record (MAR) for August 2023 has the medication being administered for 4 days - 8/5, 8/6 8/7 and 8/8. However, on 8/9/23, two pills remained in the blister pack. Resident 4 is also prescribed daily weight checks. On 8/9/23, due to gaining 10 pounds from 8/8 to 8/9, the doctor sent the resident to the emergency room. Per staff person A, this medication should have prevented the weight gain and emergency room visit. As of 8/10/23, Resident 4 remains in the hospital for observation [redacted]

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.42b. Abuse:

42b - Abuse (continued)

The Health Care Director and Staff in-serviced on the abuse. Appendix D

(Directed)
By 11/1/23, the administrator or designee will conduct training of all staff on abuse and neglect and how to report it. Specific training targeted at medication technicians will also be conducted to review what a medication error is, how to identify a medication error, and the steps to report it. This training will be documented. Moving forward, the administrator will hold a quality management review no later than 11/1/23 to review and discuss reportable incidents and conditions that have occurred.

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

42s - Privacy

5. 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 8/8/23, voice-controlled electronic devices were located in the personal care dining room and in the Harmony Square dining room. The home does not have a policy or procedures that address the use of the electronic

42s - Privacy (continued)

voice-controlled devices to include posting notification of the use of the devices in the home and addressing the use of the devices in the resident contract.

Plan of Correction ***Directed (- 09/22/2023)***

2600.42s: Privacy:
The electronic voice-controlled devices have been removed.

(Directed)
Immediately, on 8/8/23, the devices were removed by a staff person.

By 11/1/23, all staff will receive training by the administrator or designee on what an electronic voice-controlled device is, how to identify such a device, and how to notify the management of the home of the presence of such a device.

Moving forward, the home shall consult the Department's licensing website and develop and implement written procedures for the use of electronic voice-controlled devices in accordance with guidance issued on 8/17/22 and revised on 8/31/22.

42s - Privacy *(continued)*

Directed Completion Date: *11/01/2023*

Implemented [redacted] - 12/11/2023)

54a - Direct Care Staff

6. 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

Staff person B, hired [redacted]/2022, does not have a high school diploma, GED diploma, or active registry status on the Pennsylvania nurse aide registry on file.

Repeated Violation - 12/6/22. 9/27/22, et al

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.54a. Direct Care Staff:
Audit of Employee files was completed and the employee B did have a High School Diploma. All other employees have been audited and are in compliance with regulations. See Appendix E &F

(Directed)
An audit of all employee files was completed and the employee B did have a High School Diploma. All other employee records have been audited and are in compliance with regulations.

By 11/1/23, hiring staff will be trained by the administrator or designee on the requirement to obtain a high school diploma for direct care staff. On a monthly basis for three months, the administrator or designee shall conduct an audit of all new direct care staff records to ensure that each one contains a high school diploma or GED. The audits shall be documented.

54a - Direct Care Staff (continued)

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

63a - First Aid/CPR Training

7. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 7/26/23 from 11:00 PM to 7:00 AM, there were 79 residents in the home. There were 5 staff working in the home and only 1 staff member was certified in first aid. No staff were certified in CPR.

On 7/27/23 from 11:00 PM to 7:00 AM, there were 80 residents in the home. There were 4 staff working in the home and only 1 staff was certified in CPR and first aid.

On 7/29/23 from 11:00 PM to 7:00 AM, there were 81 residents in the home. There were 5 staff working in the home and only 1 was certified in CPR and first aid.

Repeated Violation - 9/27/22, et al

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.63a First Aid and CPR:
Agency staff has been utilized in the building to help maintain compliance until CPR/first aid is completed by all clinical staff that have an expired certificate. Classes have been set up with Cintas for the clinical and dining staff for October10 and 11th. See agency receipts Appendix G agency receipts and CPR class scheduled.

(Directed)
Starting 8/8/23 the administrator or designee shall ensure that there is at least one staff person working on each shift with current CPR and First Aid certification for each 50 residents. This shall be determined by making a list of all staff with current CPR and First Aid certifications and reviewing staff schedules to ensure the appropriate ratio

63a - First Aid/CPR Training (continued)

of trained staff is present in the building for all shifts. Beginning 11/1/23, the administrator or designee shall document the review of staff schedules and CPR / First Aid reconciliation on a weekly basis for three months.

Directed Completion Date: *11/01/2023*

Implemented [redacted] - 12/11/2023)

65g - Annual Training Content

8. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Staff person C, hired on [redacted]/20, did not receive annual training in the areas of fire safety by a fire safety expert or staff trained by fire safety expert, emergency preparedness procedures, resident rights, Older Adults Protective Services Act (OAPSA), falls and accident prevention, and new population groups (if applicable).

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.65g: Annual Training Content:

65g - Annual Training Content (continued)

Business Office Manager or designee to audit employee files by 09/18/2023. Business Office Manager to track trainings for all applicants. Training sheets will be kept in the employee file moving forward. Please see appendix H and I .

(Directed)
All staff files have been audited by the business office manager as of 9/18/23 to ensure compliance with the requirement to be trained in the areas of fire safety, emergency preparedness procedures, resident rights, Older Adults Protective Services, falls and accident prevention, and new population groups. Staff person C was trained in these areas by 9/1/23. A personnel file checklist will be implemented to ensure compliance to all new hired staff persons by 9/1/23. Beginning 11/1/23, the Executive Director or Business Office Manager will continue to audit files monthly for completeness.

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

81b - Resident Personal Equipment

9. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

81b - Resident Personal Equipment *(continued)*

Description of Violation

On 8/10/23, Resident 4 was observed having an uncovered enabler bar installed on their bed. The enabler measures 20 inches high and approximately 10 inches wide above the mattress, causing a potential entrapment risk.

Repeated violation - 3/29/23

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.81b. Resident Personal Equipment:
Maintenance completed audit of the personal care and Memory care unit and all enabler bars are within compliance. Moving forward nursing will keep and audit sheet of all admissions and current residents to make sure we maintain compliance.

(Directed)
As of 9/15/23, all resident apartments have been audited to identify any resident that may have a potential risk from the enabler bar. The enabler bar attached to the bed for Resident 4 has been removed as of 9/7/23. The Executive Director or designee will educate all residents and families that require the use of an enabler bar to purchase an enabler bar with an opening of less than 4 ¾ inches.
Moving forward, the administrator or designee will keep an audit sheet of all admissions and current residents utilizing enabler bars and they will be checked on a monthly basis starting on 11/1/23, to ensure that they are securely mounted and do not contain openings greater than 4 3/4 inches.

Directed Completion Date: *11/01/2023*

Not Implemented [redacted] - 12/11/2023)

82a - Poisonous Materials

10. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 8/10/23 at 11:18 AM, a clear spray bottle was observed next to the toilet in Resident 2's bathroom. The spray bottle had clear liquid in it and did not have a manufacturer's label.

8/10/23 at 11:40 AM there was a clear spray bottle filled with green liquid on the 2nd floor med station. The bottle did not have a manufacturer's label.

82a - Poisonous Materials *(continued)*

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.82a Poisonous Materials:
Maintenance completed an audit of all housekeeping bottles to be labeled and stored in the original containers. All materials in compliance. Maintenance Director or designee to complete weekly audits to maintain compliance. See attached

(Directed)
The two spray bottles with unidentified liquids were immediately removed and disposed of on 8/8/23. By 11/1/23, all housekeeping staff will be trained by the administrator or designee on regulation 82a and use and storage of poisonous materials. Moving forward, by 11/1/23, the administrator or designee will complete weekly audits to measure compliance with this regulation.

Directed Completion Date: *11/01/2023*

Not Implemented [redacted] - 12/11/2023)

82c - Locking Poisonous Materials

11. Requirements

82c - Locking Poisonous Materials *(continued)*

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 8/8/23 at 9:45 AM, a 32 oz spray bottle of Great Value All Purpose Cleaner with Bleach was in Resident 5's bathroom. The bottle had a label stating to call a poison control center or doctor for treatment advice. This resident resides in the SDCU and is not assessed to safely use poisonous materials.

Repeated violation - 9/27/22, et al

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.82c: Locking poisonous materials
Housekeeping staff in-serviced on the correct way to store poisonous materials. Maintenance or designee to complete audits weekly to maintain compliance on the SDCU. See attached

(Directed)
Immediately, on 8/8/23 the bottle of all-purpose cleaner was removed from the resident's room by staff. By 11/1/23, all housekeeping staff will be trained by the administrator or designee on regulation 82c and use and storage of poisonous materials. Moving forward, by 11/1/23, the administrator or designee will complete weekly audits to measure compliance with this regulation.

82c - Locking Poisonous Materials (continued)

Directed Completion Date: *11/01/2023*

Implemented [redacted] - 12/11/2023)

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

On 8/10/23 at approximately 1:00 PM, the sheets in Resident 6's room were wet to the touch at the bottom, middle and top of the bed. The resident stated that the bedding had not been washed this day.

A black mold-like substance was observed on the ceiling near the vent in bedroom H125.

The lift chair in Resident 7's room is heavily soiled with dark-colored stains which appear to be urine and feces.

Comparing blood sugar readings stored on glucometers against the medication administration records, it was determined that the glucometer for Resident 8's glucometer was used to check Resident 9's blood sugar on 8/10/23, 8/8, 8/7, and 8/6.
Resident 10's glucometer was used to check Resident 11's blood sugar on 8/9/23, and 8/8.

Repeated violation - 3/29/23, 9/27/22, et al

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.85a. Sanitary Conditions:
New Glucometers have been distributed on the units. The Glucometer bag has a picture of the resident on the bag to maintain compliance of each resident having a designated glucometer. All ceiling vents on the SDCU were cleaned and the Maintenance Director will complete annual inspections and cleanings.

(Directed)
Immediately on 8/8/23 staff removed and laundered the linens in Resident 6's apartment. Beginning 11/1/23, staff designated by the administrator who will check Resident 6's linens twice daily to ensure that they are clean, dry, and sanitary. These checks will occur for a month and begin by 11/1/23. The checks will be documented and include the written name of the person checking the linens, the time and date of the check, and the condition of the linens and any remediation that occurs.

The mold like substance near the vent in apartment H125 has been cleaned and treated by maintenance staff as of 9/15/23. By 11/1/23, staff will create and use an audit tool while checking the areas around ventilation grates in each room on a semi-annual (twice yearly) basis. The audit tool will include the date of the audit, the room number audited, the staff person responsible for the audit, and any corrective action that occurred.

85a - Sanitary Conditions (continued)

As of 9/15/23, lift chair in Resident 7's room has been cleaned. By 11/1/23, the administrator or a designee shall conduct a check of all rooms to identify unsanitary conditions. On a weekly basis starting no later than 11/1/23, the home shall develop and use a weekly audit sheet to check the condition of the lift chair in Resident 7's room for cleanliness and sanitation. These checks shall occur for no less than 3 months.

As of 11/1/23, all glucometers in the home will be replaced with new ones. Each glucometer and pouch will be labeled with the resident's name, at a minimum. As of 11/1/23, all medication technicians will be trained on checking blood sugar with only the resident's designated glucometer. Moving forward, the administrator or designee will document weekly comparisons of blood sugar readings stored in resident glucometers against readings documented by staff. These audits will begin by 11/1/23 and occur for 2 months and will include any problems identified and remediation action taken.

Directed Completion Date: *09/15/2023*

Not Implemented ([redacted] - 12/11/2023)

85e - Trash Outside Home

13. 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

The trash dumpster was full of trash and was missing the right-side lid. The lids on the recycling dumpster were pushed upward by overflowing trash bags which staff person D stated was regular trash that had been disposed of in the wrong dumpster.

Plan of Correction ***Directed [redacted] - 09/22/2023)***

2600.85.e Trash Outside the Home:
The trash receptacle has been replaced with a new receptacle. Please see appendix N

(Directed)
As of 9/15/23, the dumpster lid has been replaced. By 11/1/23, housekeeping, maintenance, and dietary staff will be educated on this regulation. By 11/1/23, the administrator shall designate someone to conduct once daily checks of the dumpsters to ensure that they are in good repair and are closed when not actively being used. These checks will occur for no less than a month and will include the date and time of the check, the name of the person checking, and any remedial actions taken.

85e - Trash Outside Home (continued)

Directed Completion Date: *11/01/2023*

Not Implemented [redacted] 12/11/2023)

86a - Ventilation

14. Requirements

2600.
86.a. All areas of the home that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

Description of Violation

The ventilation grates in multiple bedrooms, including in H141, were covered with lint and cobwebs which impedes the flow of air into the heating ventilation and air conditioning units.

Plan of Correction ***Directed ([redacted] 09/22/2023)***

2600.86.a Ventilation:
All ceiling vents have been assessed and cleaned in the SDCU. The Maintenance or designee to complete annual inspections and cleaning.

(Directed)
By 11/1/23, all ceiling vents in resident bedrooms shall be assessed and cleaned. Beginning 11/1/23, staff will create and use an audit tool while checking the areas around ventilation grates in each room on a semi-annual (twice yearly) basis. The audit tool will include the date of the audit, the room number audited, the staff person responsible for the audit, and any corrective action that occurred.

86a - Ventilation (continued)

Directed Completion Date: *11/01/2023*

Implemented ([redacted] 12/11/2023)

89a - Water Pressure

15. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 8/9/23, the maximum hot water temperatures in Resident 4's room measured 76 degrees; Resident 10's room, 78 degrees; and Resident 12's room measured 90 degrees. On 8/10/23, the maximum water temperature in Resident 4's room was 74 degrees.

Plan of Correction ***Directed ([redacted] 09/22/2023)***

2600.89a. Water Pressure
A pump has been installed in room 214 due to water temperature. Maintenance will continue to audit temps weekly at five rooms a week. Appendix O &P

(Directed)
As of 9/15/23, a pump has been installed in room 214 to assist with providing hot water. Beginning no later than 11/1/23, the maintenance director shall create and use an audit tool to conduct water temperature monitoring of the affected rooms, including room 214, as well as at least 5 additional water sources in the home. The audits will occur weekly for two months and will include the date of the audit, the room number or location of the sink checked, the temperature of the water, and any problems or remediation taken as a result of the audit.

89a - Water Pressure (continued)

Directed Completion Date: *11/01/2023*

Not Implemented ([redacted] - 12/11/2023)

105g - Lint Removal and Duct Cleaning

16. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 8/8/23 there was an accumulation of lint in the lint trap of the Speed Queen dryer in the SDCU. There were no clothes in the dryer at the time.

Plan of Correction ***Directed [redacted] - 09/25/2023)***

2600.105.g Lint Removal and duct cleaning:
Staff educated on lint removal and fire hazards of lint. Maintenance or designee to complete daily audits of lint trap.
See attached

(Directed)

105g - Lint Removal and Duct Cleaning (continued)

As of 9/15/23, the administrator or designee has provided training to all staff on this regulation including the need to clean lint from the lint trap and drum of the dryer upon removal of laundry. Beginning 11/1/23, a maintenance staff person or other designated person will complete daily audits of all lint traps in all dryers for a month to ensure that lint is removed after each load of laundry.

Directed Completion Date: *11/01/2023*

Implemented [redacted] - 12/11/2023)

107c - Food/Water 3 Day Supply

17. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 8/9/23, the home served 79 residents, requiring 237 gallons of emergency drinking water. However, the home had only 105 gallons on-site. The home does not have a current contract with a local bottled water supplier that includes a guarantee of delivery even in the event of regional emergency.

Plan of Correction ***Directed [redacted] - 09/25/2023)***

107c Food/Water 3 day supply:
Dining Director Educated on the correct amount of water to maintain compliance with regulations. The Dining Director ordered water for the appropriate number of residents and will rotate stock as needed. See attached

107c - Food/Water 3 Day Supply (continued)

(Directed)

As of 9/15/23, the dining director has been educated by the administrator on the requirements of this regulation; the home has since ordered a sufficient amount of water to ensure an adequate amount of water is present in the home to meet the needs in the event of an emergency. The dining director will monitor the supply of water and rotate stock as needed. Moving forward, the administrator or designee will coordinate with the dining director to compare the amount of residents in personal care versus the amount of water on-hand to ensure that there is a minimum of 3 gallons of water present for each personal care resident. This reconciliation will occur monthly beginning no later than 11/1/23 and shall be documented on a form that the home creates that includes the number of personal care residents living in the home and the amount of water, in gallons, on-hand.

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

141b1 - Annual Medical Evaluation

18. Requirements

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

Description of Violation

Resident 13's last medical evaluation was completed [redacted]/21.
Resident 1, admitted [redacted]/21, has not had a medical evaluation as of [redacted]/2023.

141b1 - Annual Medical Evaluation (continued)

Plan of Correction ***Directed [redacted] - 09/25/2023)***

141.b.1

An audit will be performed by the Health Care Director or designee by 9/15/2023 to identify all residents that could be affected by this practice. The Healthcare Director will reeducate all staff members that are certified to perform medication administration to the residents on the policy and procedure of medication administration. All staff members that are certified will be required to be observed by the Operations Specialist who is train the trainer certified to ensure compliance with the policy and procedure for medication administration. This will be completed by 9/15/23. See Inservice Sheet Attached

(Directed)

The administrator or designee will audit all resident files to identify residents who require an updated medical evaluation by 11/1/23. The home shall arrange for a current medical evaluation to occur for those residents who require a new one. New medical evaluations, including for Residents 1 and 13, shall occur or be scheduled by 11/1/23. By 11/1/23, the administrator or designee will create a spreadsheet or other monitoring tool that tracks all resident medical evaluations so that new medical evaluations can be scheduled and obtained within 365 days from the previous one.

Directed Completion Date: *11/01/2023*

Implemented [redacted] - 12/11/2023)

182c - Medication Administration

19. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

On 7/18/23, Resident 4's medications were found sitting in a cup in [redacted] room by a visitor with no staff present in the room. This was reported to staff person A.

Plan of Correction ***Directed ([redacted] - 09/25/2023)***

Medication Assocaites in serviced and retrained by a certified Train the Trainer regarding proper medication administration.

(Directed)
All staff who pass medications shall receive training / in-service by a certified medication trainer on the steps to administering medications. All direct care staff, including those who do not administer medications, shall receive training / in-service by the administrator or designee on what to do if loose or unattended medications are found in the home. These trainings shall be documented and shall occur by 11/1/23. Beginning 11/1/23, the administrator or designee shall conduct weekly walk-throughs of the home including a sample of resident rooms, to check for unattended medications. These walk-throughs shall be documented, include the areas that are checked, the date and time of the check, and the results of the walk-through including any loose or unattended medications that are found, as well as remedial action taken.

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

182c - Medication Administration *(continued)*

183b - Meds and Syringes Locked

20. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 8/8/23 at 9:30 AM, a small round white pill labeled "U5" was found on the Harmony Square dining room floor.

On 8/8/23 at 10:15 AM, the door to room 229 was propped open and the room was unattended. A 160-tablet bottle of Tums Ultra Strength was sitting on the microwave to the left of the door and a 6 oz bottle of Vick's Vapor Rub was sitting on the windowsill.

On 8/09/23 at 2:15 PM, there was a tub of Triamcinolone Cream, on Resident 14's bathroom vanity. Resident 14 is not assessed to self-administer medications.

On 8/9/23 at 2:30 PM, there was a tube of Diclofenac Solution, 1%,in Resident 15's room. The tube was still present in the room on 8/10/23. Resident 15 is not assessed to self-administer medications.

On 8/9/23 at 3:00 PM, there were two tubes of Triamcinolone 0.1% solution in a plastic baggie on Resident 4's bathroom vanity. On 8/10/23, a tube of Diclofenac Sodium topical gel, hydroguard cream, Rite Aid Dry Mouth Lozenges, and TheraBreath Dentis formulated dry mouth lozenges were observed on a table in Resident 4's living room. Resident 4 is not assessed to self-administer medications and the bedroom was unlocked, unoccupied, and accessible on the dates noted.

On 8/10/23 at 10:40 AM, the third-floor medication room was unattended, unlocked, and accessible. The room contained medications that were to be returned to the pharmacy in an open blue storage tote, in bags that were coming into the home, and also medications stored in the refrigerator. Medications included included a full card of Hydralazine 50 MG tablets for Resident 8; a full card of Promiprexale 0.25 MG tablets for Resident 16, and a Lantus Solostar pen prescribed for Resident 7.

On 8/10/23 at 11:38 AM, the 2nd floor med station was unattended. The door behind the med station was unlocked and inside the room was a red cart filled with medications, two brown paper grocery bags filled with medications and additional medications in the cabinets. Sample of meds found included Resident 4's Duloxetine 60 MG and Resident 17's Acetaminophen 500 MG.

On 8/10/23, Resident 7's door was propped open and the room was unattended and accessible. The following medications were visible from the hallway and accessible to anyone: Vitamin E 150 MG softgels; Miconazorb AF powder, 2%, two bottles; Clearlax Polyethylene Glycol 3350 (17.5 oz container); Claritin 5 mg tablets; Metamucil 72 count gummies; Lidocaine Pain Relieving Cream, 4.3 oz tube.

Repeated violation - 9/27/22, et al

Plan of Correction ***Directed [redacted] - 09/25/2023)***

183b - Meds and Syringes Locked (continued)

183.b.
An audit was performed of all resident apartments and all medication storage areas to ensure appropriate locks are available and in working condition. A safety audit of resident apartments has been completed to ensure that any medication is stored properly, if permitted to be stored in the apartment. Healthcare Director will reeducate all staff members that are certified to perform medication administration to the residents on the policy and procedure for the storage of medication. This reeducation will be completed by 9/15/2023. The Health Care Director or designee will perform a weekly audit of 5 resident apartments and medication areas to ensure compliance to this policy and procedure. See attached

(Directed)

Immediately on 8/8/23, the medications that were observed were secured by the home. All staff who pass medications shall receive training / in-service by a certified medication trainer on the steps to administering medications. All direct care staff, including those who do not administer medications, shall receive training / in-service by the administrator or designee on what to do if loose or unattended medications are found in the home. These trainings shall be documented and shall occur by 11/1/23. Beginning 11/1/23 the administrator or designee shall conduct weekly walk-throughs of the home including a sample of resident rooms, to check for unattended medications. These walk-throughs shall be documented, include the areas that are checked, the date and time of the check, and the results of the walk-through including any loose or unattended medications that are found, as well as remedial action taken.

Directed Completion Date: *11/01/2023*

183b - Meds and Syringes Locked *(continued)*

Implemented [redacted] - 12/11/2023)

183f - Discontinued Medications

21. Requirements

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

Description of Violation

On 8/8/23, staff person E was observed discarding a loose white pill into the trash bin on the side of the medication cart in the Harmony Square SDCU. Throwing medication into the trash is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

Plan of Correction ***Directed ([redacted] - 09/25/2023)***

183.f.
The Executive Director or Healthcare Director will reeducate staff person E on the policy and procedure for discarding and destroying medication. This reeducation will take place by 9/18/2023. The Healthcare Director will observe destruction of medications monthly to ensure ongoing compliance.

(Directed)
Immediately on 8/8/23, the medication was removed from the trash and properly disposed of. As of 9/18/23, staff person E was re-educated on proper methods of medication disposal. By 11/1/23, all staff who pass medications will receive training by the administrator or designee on proper methods of medication disposal.

183f - Discontinued Medications (continued)

Directed Completion Date: *11/01/2023*

Implemented [redacted] - 12/11/2023)

185a - Implement Storage Procedures

22. 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

Resident 2 has an order for Sertraline HCL 25 MG - take 1 tablet by mouth daily for depression. This medication was not available in the home on 8/9/23.

Resident 18 is prescribed Pregabalin 75 MG, two capsules by mouth nightly. On 8/10/23, there were 9 doses (18 tablets) but the controlled substance count states there should be 10 doses (20 tablets) remaining.

Resident 11 has a current order for Lisinopril 20 MG. On 8/10/23, this medication was not available in the home.

Plan of Correction ***Directed ([redacted] - 09/25/2023)***

185.a.
All staff members that are certified to perform medication administration will have a mandatory reeducation on the policy and procedures for medication administration and documentation. Healthcare Director or designee will perform a weekly audit on the Controlled Substance Log to ensure the documentation and count of medications are correct. The training will be completed by 9/15/2023

(Directed)
By 11/1/23, the administrator or designee shall audit all controlled substances to ensure that the amount of medication on-hand matches the record that the home has. By 9/15/23, all staff who are certified to perform medication administration shall be be re-educated on the policy and procedure for medication administration and documentation. The healthcare director or designee will perform a weekly audit on the controlled substances logs to ensure that the counts are correct. The weekly audits will be documented and include the name of the residents being audited, the names of each controlled substance prescribed for that resident, and the count documented versus the quantity of the medication in the home. These audits will begin no later than 10/6/23 and will occur for no less than 4 weeks.

185a - Implement Storage Procedures (continued)

Directed Completion Date: *11/01/2023*

Not Implemented [redacted] - 12/11/2023)

187a - Medication Record

23. Requirements

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

Description of Violation

On 8/5/23, Resident 3 did not receive [redacted] Lidocaine pain relief patch however the MAR was signed by staff person F as being applied at 8:00 AM.

On 8/5/23, Resident 17 did not receive [redacted] Lidocaine Pain Relief Patch 4%., however the MAR was signed by staff person F.

Resident 2 has an order for Sertraline HCL 25 MG - take 1 tablet by mouth daily for depression. Staff person A stated this medication has not been available in the home, however, it has still been initialed as given.

Resident 4 received an order on 8/4/2023 for Zaroxolyn 2.5 MG - take 1 tablet by mouth 2 times a day at 8:30 AM for 3 days. The MAR for August 2023 has the medication being administered for 4 days- 8/5, 8/6 8/7 and 8/8. However, on 8/9/2023. this medication was found to have two pills remaining in the blister pack.

Repeated Violation – 3/29/23

187a - Medication Record *(continued)*

Plan of Correction ***Accept [redacted] - 09/25/2023)***

187.a.
All staff members that are certified to perform medication administration will have a mandatory reeducation on the policy and procedures for medication administration and documentation. All medication carts and resident orders have been audited to ensure availability of all medications. The Executive Director, Healthcare Director or designee will perform a weekly medication cart audit to ensure the availability of medications as prescribed. The training will be completed by 9/15/23.

Licensee's Proposed Overall Completion Date: *09/19/2023*

Not Implemented [redacted] - 12/11/2023)

187d - Follow Prescriber's Orders

24. Requirements

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

Description of Violation

On 8/1/23 at 10:00 AM, Resident 1 did not receive prescribed Escitalopram 10 MG, Levothyroxine 75 MCG, Losartan Potassium 50 MG, Metoprolol Succ ER 50 MG, or Omeprazole DR 20 MG.

Resident 4 received an order on 8/4/23 for Zaroxolyn 2.5 MG, take 1 tablet by mouth 2 times a day at 8:30 AM for 3 days. The MAR for August 23 has the medication being administered for 4 days - 8/5, 8/6 8/7 and 8/8 - however, on 8/9/23, this medication was found to have two pills remaining in the blister pack.

Resident 2 has an order for Sertraline HCL 25 MG, take 1 tablet by mouth daily for depression. This medication was not available in the home on 8/9/23 to be given.

Resident 19 received orders to D/C Baclofen liquid, Oxycodone TID and PRN and Mylanta liquid on 4/21/23. Oxycodone and Mylanta were administered through 4/24/23.

On 8/5/23, Resident 3 did not receive [redacted] Lidocaine pain relief patch.

Repeated violation - 3/29/23, 9/27/22, et al

Plan of Correction ***Accept [redacted] - 09/25/2023)***

187.d.
All staff members that are certified to perform medication administration will have a mandatory reeducation on the policy and procedures for medication administration and documentation. Healthcare Director or designee will perform medication administration observations on the staff members that are certified to perform medication administration by 9/15/23. The training will be completed by 9/15/23.

Licensee's Proposed Overall Completion Date: *09/19/2023*

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

Not Implemented ([redacted] - 12/11/2023)

188b - Medication Error Reporting

25. 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

On 8/1/23 at 10:00 AM, Resident 1 did not receive prescribed Escitalopram 10 MG, Levothyroxine 75 MCG, Losartan Potassium 50 MG, Metoprolol Succ ER 50 MG, or Omeprazole DR 20 MG. These medication errors were not reported to the prescriber.

Plan of Correction ***Directed [redacted] - 09/25/2023)***

188.b.
The Executive Director or Healthcare Director will reeducate all staff members that are certified to perform medication administration on the policy and procedures of medication errors by 9/15/23. The Healthcare Director or designee will audit documentation in the residents' chart to ensure that the residents prescriber has been notified upon medication errors when they occur.

(Directed)
The medication errors described in this violation were reported to the prescriber by the home and the prescriber's response is in the resident's record.

By 11/1/2023, the administrator or designee will re-educate all staff who pass medications on this regulation. The administrator or designee will audit documentation in the residents' chart to ensure that the residents' prescriber has been notified of errors when they occur.

188b - Medication Error Reporting (continued)

Directed Completion Date: *10/06/2023*

Implemented ([redacted] - 12/11/2023)

190a - Completion Medication Course

26. 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 G, hired [redacted]/23, took the modified medication administration course on 8/11/22. Per suspended regulation guidance: Beginning August 1, 2022, staff persons must take the Standard Course. Additionally, the home has no documented MAR reviews or medication administration observations. Staff person G passed medications in August 2023 to Residents 2 and 17.

Staff person F, hired [redacted]/22, had an annual practicum completed on 2/1/22. There has not been another annual practicum since. Additionally, there is no documentation of MAR reviews or observations completed since prior to employment in the home. Staff person F passed medications during the month of August 2023 to Residents 2 and 17.

Repeated Violation - 12/6/22, 9/27/22, et al,

Plan of Correction ***Directed [redacted] - 09/25/2023)***

190.a.
The facility will perform an audit of staff files to identify any staff person that is not compliant with the required documentation on file to be able to pass medications per state guidelines by 10/02/2023. All staff members that do not have the required documentation will be removed from the schedule until the staff member can provide the community with the required documentation. The Executive Director or Business Office Manager will audit employee files monthly for required medication aide certification.

(Directed)
Immediately on 8/8/23, the staff named in this violation was pulled from administering medications until their training was updated.

The administrator or designee will conduct an audit of all staff who pass medications by 11/1/23, to ensure that

190a - Completion Medication Course (continued)

their training is present and up to date. Any staff for whom the home does not have a current record of training will not be permitted to pass medications until training is current. By 11/1/23, the administrator or designee will audit employee files monthly to ensure that current training is present for any staff who pass medications.

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

190b - Insulin Injections

27. 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

Staff person F measured Resident 11's blood glucose on 8/1 at 8:00 AM, 8/5 at 8:00 AM, 8/6 at 8:00 AM, 8/7 at 8:00 AM and 8/8 at 8:00 AM and administered insulin 8/1 at 12:00 PM, 8/5 at 12:00 PM, 8/6 at 12:00 PM, 8/7 at 12:00 PM and 8/8 at 12:00 PM. Staff person F has not had diabetic training since 2/1/22.

On 8/10/23 at 11:51 AM, staff person E administered insulin to Resident 20. Staff person E has not had diabetic education in the last 12 months (since 5/26/22).

190b - Insulin Injections *(continued)*

Plan of Correction ***Directed [redacted] 09/25/2023)***

190.b.
The facility will perform an audit of staff files to identify any staff person that is not compliant with the required documentation on file to be able to per state guidelines to administer insulin by 9/1/23. All staff members that do not have the required training and documentation to administer insulin will be instructed to not administer insulin to any resident until the staff member can provide the community with the required documentation. The Executive Director or Business Office Manager will audit employee files monthly to ensure insulin training compliance.

(Directed)
Immediately on 8/8/23 the staff named in this violation was pulled from checking blood sugars or administering insulin until their training was updated.

The administrator or designee will conduct an audit of all staff who pass medications by 11/1/23 to ensure that current diabetic education is present. Any staff for whom the home does not have a current record of diabetic education will not be permitted to check blood sugars or administer insulin. By 11/1/23, the administrator or designee will audit employee files monthly to ensure that current training is present for any staff who check blood sugar or administer insulin.

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

224a - Preadmission Screen Form

28. 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 was admitted [redacted]/22 but the preadmission screening was not completed until [redacted]22.

Repeated Violation 9/27/22, et al.

Plan of Correction ***Accept [redacted] - 09/25/2023)***

224.a.
The facility will perform an audit of all resident files to ensure that the files include the preadmission screening that is required by 10/02/2023. The Healthcare Director has been educated to ensure that all resident information needed and required to determine the needs can be met by the services of the facility. The Executive Director or designee will perform an audit of new resident admission paperwork with every admission to ensure that the required preadmission assessment has been completed prior to move in. Executive Director or Business Office Manager will audit resident files monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Not Implemented [redacted] - 12/11/2023)

225a - Assessment 15 Days

29. 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 7, admitted [redacted]/23, does not have an initial assessment completed as of 8/10/23.

Resident 15, admitted [redacted]/23, does not have an initial assessment completed as of 8/10/23.

Repeated violation - 9/27/22 et. al.

Plan of Correction ***Directed [redacted] - 09/25/2023)***

225.a.
The facility will perform an audit of all resident files to ensure that the files include the initial assessment that is required to be completed within the first 15 days of admission by 10/02/2023. The Healthcare Director has been educated to ensure that all residents initial assessments are completed per state guidelines within 15 days of admission. The Executive Director or designee will perform an audit of newly moved in residents to ensure compliance of performing the initial assessment within 15 days of admission. The Healthcare Director or Executive Director will audit resident files monthly to ensure ongoing compliance.

225a - Assessment 15 Days (continued)

(Directed)
By 11/1/2023, new assessments will be completed for Residents 7 and 15.
The administrator or designee has provided education to the healthcare director on the requirements of this regulation.
By 11/1/2023, the administrator or designee will audit all resident files to ensure that they include a current assessment.
Beginning 11/1/23, the administrator or designee will perform an audit of new residents to ensure that the 15-day timeframe for completion of the assessment after move-in is met.

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

227a - Support Plan 30 Days

30. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

227a - Support Plan 30 Days *(continued)*

Description of Violation

Resident 7, admitted [redacted]23, does not have a support plan completed as of 8/10/23.

Plan of Correction ***Directed [redacted] - 09/25/2023)***

227.a.
The facility will perform an audit of all resident files to ensure that the files include the support plan that is required to be completed within the first 30 days of admission, by 10/02/2023. The Healthcare Director has been educated to ensure that all residents support plans are completed per state guidelines within the first 30 days of admission. The Executive Director or designee will perform an audit of newly moved in residents to ensure compliance of completing the support plan within 30 days of move admission. The Healthcare Director or Executive Director will audit resident files monthly to ensure ongoing compliance.

(Directed)
By 11/1/2023, a new support plan will be completed for Resident 7.
The administrator or designee has provided education to the healthcare director on the requirements of this regulation.
By 11/1/2023, the administrator or designee will audit all resident files to ensure that they include a current support plan.
By 11/1/23, the administrator or designee will perform an audit of new residents to ensure that the 30-day timeframe for completion of the support plan after move-in is met.

227a - Support Plan 30 Days (continued)

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

227c - Support Plan Revision

31. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident 5's last support plan was completed on [redacted]/22.

Repeated Violation - 9/27/22, et al.

Plan of Correction ***Accept [redacted] - 09/25/2023)***

227.c.
The facility will perform an audit of all resident files to ensure that the files include the support plan that is required to be completed or revised upon completion of the annual assessment or the residents change of condition, by 10/02/2023. The Healthcare Director has been educated to ensure that all residents support plans are completed per state guidelines annually or upon the residents change of condition. The Executive Director or designee will perform an audit of newly moved in residents to ensure compliance of completing the support plan upon the completion of the annual assessment or the residents change of condition. The Healthcare Director or Executive Director will audit resident files monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 12/11/2023)

227h - Support Plan Refuse Sign

32. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident 5's support plan, completed on [redacted]/22, is not signed by the resident or a representative of the home. nor is there any mark as to refusal or inability to sign.

Resident 18's support plan completed [redacted]/22 is not signed by the resident nor is there any notation as to refusal or inability to sign.

227h - Support Plan Refuse Sign *(continued)*

Plan of Correction ***Accept ([redacted] - 09/25/2023)***

227.h.
The facility will perform an audit of all resident files to ensure that the files include the support plan that is required to have documentation of signature or notation of inability or refusal to sign, this will be completed by 10/02/2023. The Healthcare Director has been educated to ensure that all residents support plans are sign or have a notation of the inability or refusal to sign. The Executive Director or designee will perform an audit of newly moved in residents to ensure compliance of getting the support plan signed or noting the inability or refusal to sign the support plan. The Executive Director or Healthcare Director will audit resident files monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 12/11/2023)

234a - Admission Support Plan

33. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation
Resident 5' was admitted to the SDCU on [redacted] 22, [redacted] assessment and support plan, dated [redacted] /22, was completed more than 72 hours after admission to the SDCU.

Repeated Violation - 9/27/22, et al,

Plan of Correction ***Directed [redacted] 09/25/2023)***

234.a.
The facility will perform an audit of all files of residents that reside or will reside in the secured dementia care unit to ensure that the files include the support plan that is required to be completed within 72 hours before or 72 hours after admission, by 10/02/2023. The Healthcare Director has been educated to ensure that all residents support plans are completed per state guidelines within 2 hours prior to admission or 72 hours after admission. The Executive Director or designee will perform an audit of newly moved in residents to ensure compliance of completing the support plan within 30 days of move admission. The Healthcare Director or Executive Director will audit resident files monthly to ensure ongoing compliance.

(Directed)
By 11/1/23, the administrator or designee will perform an audit of all records for residents who live in the secured dementia care unit (SDCU) to ensure that a support is present. As of 10/2/2023, the administrator provided education to the healthcare director on the requirements of this regulation. The administrator or designee will perform an audit of all new SDCU resident records to ensure that a support plan has been created and is present in the record within 72 hours of move-in. By 11/1/23, the administrator or designee will audit resident files monthly to ensure ongoing compliance.

234a - Admission Support Plan (continued)

Directed Completion Date: *11/01/2023*

Implemented ([redacted] - 12/11/2023)

254a - Records Discharge/Active

34. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 8/8/23 at 9:25 AM, the laptop on the medication cart in the SDCU was open, accessible, and unattended; two residents were sitting in front of the screen and could see the names of residents and their medication history.

On 8/9/23 at 2:10 PM, the medication cart on the second floor was unattended. The following items containing protected health information were accessible on top of the cart:
- a prescription label for Resident 4's Bumetanide tablets with diagnosis information
-an aqua-colored notebook containing room numbers and blood pressures, pulse rates, and the weight for Resident 4
- a slip of paper with Resident 10's name stating that the doctor had stopped the resident's insulin and wants blood sugar checked three times a day, three times a week, and that Resident 21's Cephalexon could not be located

On 8/9/23 at 2:40 PM, the filing cabinet inside the unattended and accessible second-floor staff area was open allowing anyone to access the resident records. The home does not have a key to secure the filing cabinets on the second or third floors and there are no gates or barriers to prevent access to the unlocked filing cabinets.

On 8/10/23 at 12:48 PM, the third-floor medication cart was unattended. On top of the medication cart was a green

254a - Records Discharge/Active (continued)

binder labeled "controlled medication record book" containing controlled medication information for all residents on the third floor including Resident 22's Tramadol 50 MG. Additionally, there was another binder labeled "vital sign documentation book 2023" which contained vitals for Resident 23 including the resident's temperature, respirations per minute, pulse. blood pressure and weight.

Repeated Violation – 3/29/23, 9/27/22, et al

Plan of Correction ***Accept [redacted] - 09/25/2023)***

254.a.
The facility will perform an audit by 10/02/2023 to ensure that all paperwork or charts that have resident personal information are stored in a confidential manner to prevent unauthorized access. All staff members will be reeducated on Confidentiality policies and procedures. The information that is stored on the medication carts will be stored in a drawer in the medication cart. The filing cabinets will be relocated behind a locked door. The Executive Director or designee will perform daily walk through to ensure compliance with keeping records secured when unattended.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Not Implemented [redacted] - 12/11/2023)

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

Facility Information

Name: *HARMONY AT HERSHEY* **License #:** *33741* **License Expiration:** *06/14/2024*

Address: *75 EAST CANAL STREET, HERSHEY, PA 17033*

County: *DAUPHIN* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *HERSHEY OPERATIONS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *04/02/2021* **Issued By:** *Labor and Industry*

Type: *I-2* **Date:** *04/02/2021* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *112* **Waking Staff:** *84*

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date:** *11/09/2023*

Inspection Dates and Department Representative

11/07/2023 - On-Site: [redacted]

11/08/2023 - On-Site: [redacted]

11/09/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *129* **Residents Served:** *74*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Harmony Square* **Capacity:** *39* **Residents Served:** *28*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *74*

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

Have Mobility Need: *38* **Have Physical Disability:** *1*

Inspections / Reviews

11/07/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/02/2023*

12/11/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

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 had physician's orders to receive Fosfomycin once every 7 days. From 9/22/2023 through 9/28/2023, Resident #1 received this medication daily. The home did not report this medication error to the Department.

Repeated Violation - 3/29/2023 & 2/16/2023

Plan of Correction ***Directed [redacted] - 12/01/2023)***

The Administrator or designee will educate Management and in-service on reportable incidents. They will be educated on the 24 hour report process. The Administrator or designee will be educate on the medication error process and reporting an a medication error timely. The administrator or designee will review three resident Medication Administration Record weekly and document any concerns. The staff will review the missed medication report at every shift and report any issues to the on call supervisor. These findings will also be reviewed at the monthly Quality management meetings.

Proposed Overall Completion Date: 12/06/2023

(Directed)
The Administrator or designee will educate Management and in-service all staff members who are responsible to submit reportable incidents to the Department on reportable incidents including the 24 hour report process by 12/22/2023. The Administrator or designee will be educated on the medication error process and reporting an a medication error timely by 12/22/2023. Beginning 12/22/2023, designated staff members will review the missed medication report at the end of each shift and report any medication errors to the on call supervisor. Beginning the week of 12/18/2023, the Administrator and/or designee will audit at least 25% of resident Medication Administration Records weekly and ensure medication errors found during the review have been reported timely to the Department. Reportable incidents will be reviewed during the monthly Quality Management meetings with the first review being held by January 12, 2024 to review reportable incidents that occurred in December 2023. Documentation of in-services and audits will be kept by the home.

Directed Completion Date: *01/12/2024*

81b - Resident Personal Equipment

2. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 11/7/2023 at 11:03 AM, resident room #212 was observed to have an enabler device on the bed with an open area measuring 18 inches wide by 6 ½ inches high. The enabler was not covered creating a potential entrapment hazard.

Repeated Violation - 3/29/2023

81b - Resident Personal Equipment *(continued)*

Plan of Correction ***Directed (- 12/01/2023)***

A complete audit was done by the Maintenance Director for all bed enablers. They have all been documented. The enabler in room 212 has been removed and replaced with a Halo. The community is currently complaint with DHS regulation and the Maintenance Director or designee will audit weekly for 3 months.

Proposed Overall Completion Date: 12/01/2023

(Directed)
An audit was completed by 12/1/2023 to ensure all bed enablers are secured and free from hazards by the Maintenance Director. The enabler in room #212 was removed and replaced with a Halo by 12/1/2023. All staff will receive an in-service on enabler use and safety by 1/1/24. Beginning 12/18/2023, weekly audits will be completed in the home by Maintenance Director or designee to ensure all enablers are free from hazard. Documentation of in-services and audits will be kept by the home.

Directed Completion Date: *01/01/2024*

82a - Poisonous Materials

3. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 11/7/2023 at 10:48 AM, two clear spray bottles were observed in the 2nd floor "Med Prep" room. One bottle contained a clear liquid and the second bottle contained a yellow/green liquid. Manufacturer's labels were not present on the spray bottles.

Plan of Correction ***Directed - 12/01/2023)***

The community has been audited all labels have been corrected and placed on the appropriate bottles. The Maintenance Director or Designee will complete audits weekly within the community to maintain compliance. The audits will be documented and dated and any findings corrected.

Proposed Overall Completion Date: 12/01/2023

(Directed)
The bottles were removed from the home or labeled with proper manufacturer's label by 12/1/2023. An audit was completed by 12/1/2023 to ensure all poisonous materials are stored in their original, labeled containers or provided with a manufacturer's label. Beginning 12/18/2023, the Maintenance Director or designee will complete weekly audits of the home to ensure on-going compliance. Education will be provided to all staff on the regulation by the Administrator or designee by 1/1/2024. Documentation of in-services and audits will be kept by the home.

Directed Completion Date: *01/01/2024*

85a - Sanitary Conditions

4. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

On 11/7/2023 at 10:38 AM, the restroom in resident room H111 was observed to have dried, smeared feces on the toilet seat and on the floor next to the commode. Soiled briefs were observed in the uncovered trashcan with used pieces of toilet paper; at least one of the briefs and pieces of toilet paper contained feces.

On 11/8/2023, at 12:08 PM, a towel covering the seat of Resident #3's bedroom chair was observed to have areas of smeared feces. Housekeeping staff confirmed the towel is only changed from the resident's chair once a week.

On 10/24/2023, Resident #6's private restroom was observed to have urine on the floor and feces on the toilet seat after another resident wandered into the room and used the bathroom.

Upon review of resident Medication Administration Records compared to resident glucometers, it was determined that on 11/1/2023 at 12:000 PM, 11/1/2023 at 8:00 PM and 11/9/2023 at 8:00 AM, Resident #3's blood glucose levels were checked using Resident #7's glucometer. Additionally, Resident #7's glucometer was used to check an unidentified resident's blood glucose level on 11/7/2023 as Resident #7 was not in the home from 11/3/2023 through 11/9/2023.

Plan of Correction ***Directed [redacted] - 12/07/2023)***

Administrator or designee will audit 5 rooms weekly for cleanliness including bedding, bathrooms. The room and date will be documented. Administrator or designee will also in-service on what is acceptable for room cleanliness. In regards to glucometer sanitation all parties will be notified regarding the incidents. The nurse will monitor the glucometers for accuracy and sanitation weekly and document checks and report any medication errors found. The nurse will also place glucometers in labeled bag with the picture of the resident, name and room number to distinguish the owner of the glucometer.

Proposed Overall Completion Date: 12/08/2023

(Directed)

- *All staff will receive education on sanitary conditions and regulation 2600.85(a) by the Administrator or designee no later than 1/1/2024. Additionally, all staff including housekeeping and direct care staff will be in-serviced on inspecting a residents bedroom and bathroom for unsanitary conditions and cleaning any areas that are observed to have feces, urine, bodily fluids, extremely unclean surfaces and/or pungent odors. Beginning 1/1/2024, the Administrator or designee will complete random weekly audits in 5 bedrooms per floor to ensure sanitary conditions are being maintained. Documentation of the education and audits will be kept by the home.*
- *All residents who receive blood sugar testing and their designated person, if applicable, will be notified by letter of the shared glucometer use in the facility and the possibility of blood borne diseases. Copies of the letters hall be maintained by the home for Department review. Each resident's physician will be notified of the shared glucometer use and all recommendations made by the physician (i.e. testing for blood borne pathogen) should be followed. Documentation of the notification to the physician, the recommendations of the physician, and the home's follow-up based on the recommendations shall be maintained by the home for Department review. All staff responsible for blood sugar testing will receive re-training from a certified diabetic educator as soon as possible. Starting 1/1/2024, the Administrator, or designee will audit the actual readings on a resident's glucometer as compared with the documented readings on the resident's Medication Administration Record. This shall be done on a weekly basis (on a 10% sample of) for the residents who*

85a - Sanitary Conditions (continued)

receive blood glucose testing. The weekly audits shall occur for a period of three months. Documentation of the observations shall be maintained by the home for Department review.

Directed Completion Date: *01/01/2024*

85e - Trash Outside Home

5. 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 11/8/2023, the lids on the right side dumpster were observed to be open; the dumpster was not in use at the time of the observation.

Plan of Correction ***Directed [redacted] 12/01/2023)***

The Dining Director or designee will educate staff on the dumpster lids and DHS regulation. The Dining Manager or designee will complete audits and document daily assessment and correct placement.

Proposed Overall Completion Date: 12/06/2023

(Directed)
The lids to the dumpster were closed by the Maintenance Director on 11/8/2023. Education will be provided to staff on the regulation by the Dining Director or designee by 1/1/2024. Beginning 1/1/2024, the Dining Manager and/or designee will complete daily audits of the dumpster to ensure on-going compliance. Documentation will be kept by the home.

Directed Completion Date: *01/01/2024*

89a - Water Pressure

6. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 11/7/2023, the maximum hot water temperature in Resident #2's bathroom sink measured 93.8 degrees; Resident #4's bathroom sink measured 95.6 degrees.

Plan of Correction ***Directed [redacted] 12/07/2023)***

The Hot water temperature has been resolved. A specific pump was ordered for the building to increase the circulation of hot water throughout the building. The invoice has been attached. The pump has been installed. The Maintenance Director or designee will check five rooms a week in the community. They will document date, room number and temperature.

Proposed Overall Completion Date: 11/30/2023

(Directed)

89a - Water Pressure (continued)

By 12/1/2023, a new pump was installed to increase the circulation of hot water throughout the building. Starting the week of 1/1/2024, the Maintenance Director or designee will complete water temperature checks in at least 5 resident rooms on each floor per week. Documentation will be kept by the home including the water temperature, room number and date of the audit. Audits will be reviewed during the home's quality management meeting.

Directed Completion Date: *01/01/2024*

101j3 - Bed/Linens/Pillows/Blankets

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 11/7/2023, Resident #3 was observed to have a fitted sheet on [redacted] bed with brown and yellow stains.

Plan of Correction ***Directed ([redacted] - 12/07/2023)***

Administrator or designee will audit 5 rooms weekly for cleanliness including bedding, bathrooms. The room and date will be documented. Administrator or designee will also in-service on what is acceptable for room cleanliness.

Proposed Overall Completion Date: 12/08/2023

On 11/7/2023, the fitted sheet was removed from Resident #3's bed. Education will be provided to direct care staff and housekeeping on regulation 2600.101(j)(3) by the Administrator or designee by 1/1/2024. Beginning 1/1/2024, the Administrator or designee will complete random weekly audits in at least 5 resident rooms per floor to ensure resident's bedding are clean and in good repair. Audits will occur for 3 months and results of the findings will be reviewed at the home's quality management meetings.

Directed Completion Date: *01/01/2024*

185a - Implement Storage Procedures

8. 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

Resident #3 is prescribed the following medications as needed which were not available in the home on 11/9/2023:

- *Glucagon 1 MG Emergency Kit - inject 1MG Intramuscularly as needed for hypoglycemia.*
- *Glucose 40% Gel - give one applicatorful by month as needed for hypoglycemia of less than or equal to 70MG/DL*

Resident #6 is prescribed the following medications as needed which were not available in the home on 11/9/2023:

- *Acetaminophen 500 MG Caplet Tylenol - take two tablets (1,000 MG) by mouth every 6 hours as needed.*
- *Hyoscyamine 0.125MG Tab - take one tablet by mouth under tongue every 4 hours as needed for secretions.*

Resident #9 is prescribed the following medications as needed which were not available in the home on 11/9/2023:

- *Anti Diarrheal 2 MG Imodium A-D Tablet - take one tablet by mouth every 6 hours as needed for diarrhea*
- *Olanzapine ODT 5 MG Tablet - dissolve one tablet in mouth every 12 hours as needed for agitation.*
- *Ondansetron HCL 4 MG Tablet - take one tablet by mouth every 6 hours as needed for nausea and vomiting.*

185a - Implement Storage Procedures (continued)

On 11/1/2023 at 7:30 AM, Resident #8's blood glucose level was documented at 262 and at 4:30 PM, the blood glucose was documented at 232. However, on 11/9/2023, these blood glucose levels were not found in Resident #8's glucometer.

Plan of Correction ***Directed ([redacted] - 12/07/2023)***

Administrator or designee to in-service Medication Associates on regulation 185a and how it pertains to medication ordering and storage. Nurse to audit Medication Cart weekly and documented.

Proposed Overall Completion Date: 12/08/2023

(Directed)

- *Resident'#3, #6 and #9 's missing medications were ordered or discontinued by the physician by 11/10/2023 by the med tech and/or DON. An initial medication cart audit will be completed by the Administrator or designee no later than 1/1/2024 to ensure medications are available in the home per the physician's orders. Education will be provided to all med tech's by the Administrator or designee on the home's policies and procedures for ordering medications to ensure they are available. Starting the week of 1/1/2024, weekly medication cart audits will be completed by the nurse or designee. Documentation of the training and audits will be kept by the home.*
- *Starting 1/1/2024, the Administrator, or designee will audit the actual readings on a resident's glucometer as compared with the documented readings on the resident's Medication Administration Record. This shall be done on a weekly basis (on a 10% sample of) for the residents who receive blood glucose testing. All med tech's will receive education on matching the resident's labeled glucometer with the proper resident prior to checking a resident's blood sugar levels. Education to be provided by the Administrator or designee by 1/1/2024. Documentation of the training and audits will be kept by the home.*

Directed Completion Date: *01/01/2024*

187a - Medication Record

9. Requirements

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

Description of Violation

On 10/8/2023, Staff Member A administered medications to residents in the home and signed the Medication Administration Record electronically with Staff Member B's credentials.

Repeated Violation - 3/29/2023

Plan of Correction ***Directed ([redacted] - 12/08/2023)***

Administrator or designee to in-service staff on regulation 187a. Administrator to assess for appropriate credentialing of staff when completing Medication Administration Record audits weekly and document completion.

187a - Medication Record (continued)

Proposed Overall Completion Date: 12/08/2023

(Directed)

- *The administrator will counsel Staff Member A regarding accurate documentation of medication administration by 1/1/2024.*
- *Beginning 1/1/2024, the Administrator or designee will observe a med pass involving Staff Member A at least twice per week to ensure proper procedures are followed. Documentation of the education and observations will be kept by the home.*

Directed Completion Date: *01/01/2024*

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

On 9/21/2023, Resident #1 received physicians orders for Fosfomycin 3 GM oral granule for reconstitution orally every 7 days. Resident #1 received daily administration of this medication from 9/22/2023 through 9/28/2023.

Resident #6 is prescribed Seroquel 25mg tablet-take one table by mouth at 3 AM for sleep disturbance. However, this medication was not administered to Resident #6 on 9/9/2023, 10/2/2023 or 10/8/2023.

Resident #6 is prescribed Docusate (Colace) Sodium 50 mg/g ML-take 10 ML's by mouth every day for constipation. However, this medication was not administered to Resident #6 from 9/6/2023 through 9/18/2023.

Resident #10 is prescribed Levothyroxine 100mcg tab (D) Synthroid 100mcg tab-take one tablet by mouth daily for Hypothyroidism. However, this medication was not administered to Resident #10 from 10/12/2023 through 10/17/2023.

Resident #11 is prescribed Rivastigmine 4.6mg/24 hour patch Exelon 4.6mg/24hr-apply 1 patch every morning, remove old patch before applying new patch for Dementia. On 10/13/2023, Resident #11 was observed to have two patches on [redacted] body.

Resident #12 is prescribed Humalog Kwikpen 100U/ML-inject per sliding scale: 151-200=3U, 201-250=6U, 251-300=9U, 301-350=12U, 351-400=15U. On 10/1/2023 at 8:00 AM, Resident #12's blood glucose was 129; 3 units were administered when no units should have been given. On 10/7/2023 at 8:00 PM, Resident #12's blood glucose was 247; 9 units were administered when the resident should have received 6 units. On 10/8/2023 at 8:00 PM, Resident #12's blood glucose was 297; 6 units were administered when the resident should have received 9 units.

Repeated Violation - 3/29/2023

Plan of Correction ***Directed ([redacted] - 12/07/2023)***

The Administrator or designee will educate Management and in-service on reportable incidents. They will be educated on the 24 hour report process. The Administrator or designee will be educate on the medication error

187d - Follow Prescriber's Orders (continued)

process and reporting an a medication error timely. The administrator or designee will review three resident Medication Administration Record weekly and document any concerns. The staff will review the missed medication report at every shift and report any issues to the on call supervisor. These findings will also be reviewed at the monthly Quality management meetings.

Proposed Overall Completion Date: 12/08/2023

(Directed)
An in-service will be provided to med tech's on administering medications per the physician's orders by the Administrator or designee by 1/1/2024. Education to include proper medication administration procedures for application of patches and administering insulin per a resident's sliding scale order. Beginning 1/1/2024, The staff will review the missed medication report at every shift and report any issues to the on call supervisor. Beginning 1/1/2024, the Administrator or designee will review 25% of resident Medication Administration Records weekly to ensure medications are administered per the physician's orders. Results of the MAR reviews will be reviewed at the home's quality management meeting. Documentation of the education and audits will be kept by the home.

Directed Completion Date: *01/01/2024*

224a - Preadmission Screen Form

11. 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 [redacted]/2023, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Directed [redacted] - 12/01/2023)***

Administrator will in-service regarding regulation 224a with both Directors of Nursing. Administrator will review prescreen forms after the nurse completes assessment for all new residents. The Director of Nursing or designee will audit all prescreens to assess for completion.

Proposed Overall Completion Date: 12/08/2023

(Directed)
An initial audit of current resident prescreens will be completed by the Director of Nursing and/or designee by 1/1/2024. Education will be provided to the Directors of Nursing on regulation 2600.224(a) by the Administrator or designee by 1/1/2024. Beginning 1/1/2024, the Administrator will review all new resident prescreens within 1 week of completion to ensure the form is completed. Documentation of audits and education will be kept by the home.

Directed Completion Date: *01/01/2024*

254a - Records Discharge/Active

12. Requirements

2600.

254a - Records Discharge/Active *(continued)*

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 11/8/2023 at 12:02 PM, a white binder labeled "Weekly Schedule for Dr. [redacted] was unlocked, unattended, and accessible on the counter of the medication administration area in the Secured Dementia Care Unit. Information contained in the binder included resident information such as Resident #5's first and last name, date of birth and medication changes.

Repeated Violation - 3/29/2023

Plan of Correction ***Directed [redacted] 12/01/2023)***

Administrator or designee to Inservice staff on DHS regulation 254a. The Administrator or designee will Inservice the physician on regulation 254a. Administrator or designee will remove all binders containing patient information to a locked area on the unit.

Proposed Overall Completion Date: 12/08/2023

(Directed)
The Memory Care Director secured the binder during the inspection on 1/1/2024. Education will be provided to all staff on regulation 2600.254(a) by the Administrator and/or designee no later than 1/1/2024. Beginning 1/1/2024, the Administrator and/or designee will complete random weekly audits in the home to ensure resident information is properly secured when not attended. Documentation of the education and completed audits will be kept.

Directed Completion Date: *01/01/2024*