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

November 28, 2023

[redacted], ADMINISTRATOR
MORAVIAN MANORS INC
300 WEST LEMON STREET
LITITZ, PA, 17543

RE: MORAVIAN MANOR
300 WEST LEMON STREET
LITITZ, PA, 17543
LICENSE/COC#: 32176

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/06/2023, 09/07/2023, 09/08/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MORAVIAN MANOR* **License #**: *32176* **License Expiration**: *06/28/2024*

Address: *300 WEST LEMON STREET, LITITZ, PA 17543*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MORAVIAN MANORS INC*

Address: *300 WEST LEMON STREET, LITITZ, PA, 17543*

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

Certificate(s) of Occupancy

Type: *C-1* **Date**: *01/09/1975* **Issued By**: *Labor and Industry*

Type: *I-2* **Date**: *09/13/2017* **Issued By**: *Borough of Lititz*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *10* **Waking Staff**: *8*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/08/2023*

Inspection Dates and Department Representative

09/06/2023 - On-Site: [redacted]

09/07/2023 - On-Site:

09/08/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *10*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *10*

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

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

Inspections / Reviews

09/06/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/28/2023*

Inspections / Reviews *(continued)*

10/10/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/14/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *10/18/2023*

11/07/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/14/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/14/2023*

11/28/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/14/2023*

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

3c - Post Current License

1. Requirements

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

Description of Violation

On 8/6/23 and 8/7/23, the home's most recent Licensing Inspection Summary dated 7/22/22, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 11/03/2023)***

Licensing Inspection Summary placed on bulletin board on 9/25/23, by Administrator, in public area and another copy will be placed in a binder at the nursing desk, incase the one on the bulletin board should go missing again. Residents in the PC area have cognitive impairment and will often move or take items to their rooms. Daily check of bulletin board to be completed by staff and Administrator and if missing they are to notify Administrator, , to have another placed on the bulletin board. Daily checks were implemented on 9/26/23. Staff were educated on 9/26/23 by Administrator regarding the regulation and the corrective action of checking it daily. Staff was shown where the LIS is posted and instructed if they see it missing to notify Administrator immediately.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented - 11/27/2023)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated , for Resident #1 was not signed by the resident.

Plan of Correction ***Accept - 11/06/2023)***

See attached.
The resident signature has been added to the newly developed Admission Checklist. Administrator, , and Clinical Coordinator, , created admission checklist to make sure all required documentation is being captured and completed in a timely manner. Admission Coordinator has been educated on the form and 25.b was reviewed with her and explained that the resident and the POA must sign the agreement, this education was done on 9/25/23 by Administrator . Resident #1 signed agreement on Audit was done on resident agreements 10/1/23 by Administrator, and as of all admission checklists will be reviewed by Administrator , for all new admissions and in Administrators absence then the Clinical coordinator, will review Admission checklist, to ensure all information is obtained and correct.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented - 11/27/2023)

26a - Quality Management Plan

3. Requirements

2600.

26a - Quality Management Plan *(continued)*

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The community as a whole has a quality management plan. However, the personal care home portion of the community have not had any involvement in the reviews of these plans, nor had been included in quality management meetings.

Plan of Correction ***Accept (- 11/06/2023)***

As of 10/19/23, AL/PC Administrator, , will be part of the Community QAPI Meeting. Administrator will include in a monthly report at QAPI meeting that includes number of admissions, any errors with admissions, number of falls, number of reportables, medication errors, staff trainings, discussions from Resident Council meetings, any complaints and any Licensing violations and corrective actions,

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented - 11/27/2023)

54a - Direct Care Staff

4. Requirements

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

Description of Violation

Direct care staff persons A and B do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept - 11/06/2023)***

See attached.
54.a was reviewed with HR Director, on 9/13/23 by the AL/PC Administrator, , that we need have a High School Diploma/GED/ active registry status on the Pennsylvania nurse aide registry, for those doing Direct Care. HR was given a copy of 2600.54.a for the reference. Violation was corrected on 9/19/23 when both employees were able to produce a copy of the high school diploma and these were added to their HR files at that time. All files have been reviewed, and audit was completed on 9/18/23 by Administrator and HR , no other files had missing documents. Diplomas/GEDs was added to list of documents required for new hires, such as PCAs as of 9/18/23.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented - 11/27/2023)

63a - First Aid/CPR Training

5. 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

At all of dates and time listed below, there were ten residents in the Personal Care Home. For these dates and times, the home did not have anyone working who was trained in first aid and certified in obstructed airway techniques and CPR.

63a - First Aid/CPR Training (continued)

8/13/23 from 3:15 PM to 11:00 PM
8/16/23 from 4:30 PM to 11:00 PM
8/17/23 from 4:30 PM to 11:00 PM
8/21/23 from 4:30 PM to 11:00 PM
8/22/23 from 4:30 PM to 11:00 PM.

Plan of Correction ***Accept (- 11/06/2023)***

A nurse has been added to the schedule to make sure that someone is always on the schedule that is certified in CPR/First Aid, until all staff that only have CPR can be certified in First Aid. This policy was reviewed with our Nursing Assistant, who schedules staff for CPR/First Aid Training. ALL Direct Care staff MUST have CPR/First Aid training. All staff that currently only have CPR training are scheduled for First Aid Training on 11/19/23 from 1430-1630. Administrator, goes the weekly schedule and is making sure that for every 35 resident there is at least 1 staff member trained in CPR/First Aid on every shift.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented (- 11/27/2023)

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff persons A and B, hired on and respectively, have been providing unsupervised ADL services. Neither of the staff persons have completed and passed the Department-approved direct care training course and passed the competency test.

Plan of Correction ***Accept (- 11/06/2023)***

HR Director, was educated on 9/13/23 on requirement was given a copy of Reg 2600.65.d and an extra day of orientation will be added for all Direct Care staff to make sure they have the required Direct Care staff training. 9/27/23 staff that do not have their Direct Care training will be assigned a time to be off the floor so they can complete the training. Course will be taken through Temple on line. Staff person A completed Direct Care Training on 9/28/23 and Staff Person B is scheduled to complete Direct Care Training on 10/30/23. The requirement for the PCA's has been added to the new hire checklist by Administrator, . Administrator will review all new hire files for Personal Care, to make sure no required trainings or documents are missing.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented (- 11/27/2023)

66c - Training Documentation

7. Requirements

2600.

66c - Training Documentation *(continued)*

66.c. Documentation of compliance with the staff training plan shall be kept.

Description of Violation

The home has a staff training plan in place for 2023. However, the monthly trainings ceased in April 2023, The home has not maintained documentation of the completion of courses in the staff training plan including but not limited to infection control, POC training, falls and accident prevention, emergency preparedness and safe management techniques.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

See attached.
All Med Techs were trained in June, Diabetic training was done in July, Raizer Lift Training in August, September we are reviewing inspection with staff, October all Direct Care staff will have their Direct care Training(thru Temple), November is Fire Drill re-education and December is Dementia Training. We are currently working on our Annual Training for 2024. Training plans were created by Administrator [redacted] and Clinical Coordinator, [redacted] and both will be doing trainings or coordinating qualified trainers for the trainings.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/27/2023)

96a - First Aid Kit

8. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the nurse's station does not include goggles or eye coverings.

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

See attached.
The goggles from the First Aid in the Nurse's Station have been replaced on 9/25/23 by Clinical Coordinator, [redacted]. First Aid kit monthly checks will be completed by the 3rd shift nursing staff, [redacted], LPN or [redacted] LPN, starting the first week of October, between the 1st and the 5th and will continue monthly. A required list of what needs to be in the First Aid kit is included on the checklist. Education was done on 9/26/23 to staff by Administrator [redacted] and Clinical Coordinator [redacted] on Regulation and Violation. If [redacted] or [redacted] has found anything missing on their monthly checks they are to notify the Administrator or Clinical Coordinator immediately. Clinical Coordinator will be follow up on checklists monthly to make sure they are completed.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented ([redacted] - 11/27/2023)

132a - Monthly Fire Drill

9. Requirements

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

132a - Monthly Fire Drill *(continued)*

Description of Violation

An unannounced fire drill was not held during the months of November 2022, December 2022 and May 2023.

Plan of Correction ***Accept (- 11/06/2023)***

Administrator, is working with Maintenance Director, , to have fire drills in each area for each license monthly. Copy of regulation provided to Maintenance Director, , and education done with staff who monitor drills by Administrator on 9/20/23. This was corrected at the next Fire Drill held, which was 10/11/23. Whichever staff does the fire drill, all paperwork is to be scanned in and sent to Administrator and Maintenance Director to review to make sure everything is done accurately and all fire drill documents are kept in a fire drill log binder, in monthly order by license, in the Administrators office. There is a yearly calendar in the front of the Fire Drill log book to verify that a monthly drill was done, when the paperwork has been received. If anything is missing or incomplete the Administrator, will address with Maintenance Director so corrections can be made and re-education can be done, if needed.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented (- 11/27/2023)

132c - Fire Drill Records

10. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 1/17/23 does not include the number of residents evacuated.

The fire drill record for the drills conducted on 3/21/23, 4/12/23, 6/20/23 and 7/19/23 do not include the evacuation time, number of residents evacuated, number of staff evacuated nor exit route used.

Plan of Correction ***Accept (- 11/06/2023)***

See attached.
Facility will be utilizing DHS Fire Drill Record. Copy of regulation provided to Maintenance Director, and education done with staff who monitor drills by Administrator on 9/20/23. This was corrected at the next Fire Drill held, which was 10/11/23. Whichever staff does the fire drill, all paperwork is to be scanned in and sent to Administrator and Maintenance Director to review to make sure everything is done accurately and all fire drill documents are kept in a fire drill log binder, in monthly order by license, in the Administrators office. There is a yearly calendar in the front of the Fire Drill log book to verify that a monthly drill was done, when the paperwork has been received. If anything is missing or incomplete the Administrator, will address with Maintenance Director so corrections can be made and re-education can be done, if needed.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented (- 11/27/2023)

132e - Fire Drill Sleeping Hours

12. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 8/20/23 at 12:25 am. The previous sleeping hours fire drill was conducted on 10/14/22 at 5:23 am.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

On 9/20/23 a copy of Regulation 132.e, was provided by Administrator, [redacted], to Maintenance Director, [redacted] and education was done on the regulation and explained that twice a year a sleeping hours fire drill needs to be done and that silent alarms are NOT allowed, education done by Administrator [redacted]. Alarms MUST be activated. [redacted] was educating [redacted] staff on the regulation and the importance of doing a sleeping hours drill. That the residents and staff need to be prepared incase of a real fire and they would need to evacuate. They need to practice what to do so they are better prepared. Whichever staff does the fire drill, all paperwork is to be scanned in and sent to Administrator and Maintenance Director to review to make sure everything is done accurately and all fire drill documents are kept in a fire drill log binder, in monthly order by license, in the Administrators office. There is a yearly calendar in the front of the Fire Drill log book to verify that a monthly drill was done, when the paperwork has been received. If anything is missing or incomplete the Administrator, [redacted] will address with Maintenance Director [redacted] so corrections can be made and re-education can be done, if needed. If drill is unsuccessful and drill will be completed until it is successful.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/27/2023)

132i - Testing Fire Alarm

13. Requirements

2600.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

During the fire drill on 8/20/23, the fire alarm was not sounded. In its place, a "silent fire drill" was conducted with fire activity being placed at room 154.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

On 9/20/23 a copy of Regulation 132.i, was provided by Administrator, [redacted], to Maintenance Director, [redacted] and education was done on the regulation and explained that twice a year a sleeping hours fire drill needs to be done and that silent alarms are NOT allowed, education done by Administrator [redacted]. Alarms MUST be activated. [redacted] was educating his staff on the regulation and the importance of doing a sleeping hours drill. That the residents and staff need to be prepared incase of a real fire and they would need to evacuate. They need to practice what to do so they are better prepared. Whichever staff does the fire drill, all paperwork is to be scanned in and sent to Administrator and Maintenance Director to review to make sure everything is done accurately and all fire drill documents are kept in a fire drill log binder, in monthly order by license, in the Administrators office. There is a yearly calendar in the front of the Fire Drill log book to verify that a monthly drill was done, when the paperwork has been received. If anything is missing or incomplete the Administrator, [redacted] will address with Maintenance Director [redacted] so corrections can be made and re-education can be done, if needed. If drill is unsuccessful and drill will be completed until it is successful.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/27/2023)

141a 1-10 Medical Evaluation Information

14. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation dated [redacted] did not include the resident's height, weight, pulse, temperature, or blood pressure.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

Administrator, [redacted] and Clinical Coordinator, [redacted] will be completing what we can ahead of time and highlighting on the form what the Physician needs to complete. Resident #1 evaluation form was completed on [redacted], by Administrator [redacted], who contacted Physician for verbal to correct form. As of 10/1/23, all evaluation forms are not to be placed in chart until they are initialed by [redacted] or [redacted], after review, and if form is incomplete the Physician will be contacted for a verbal order to correct information. This will be completed by Administrator or Clinical Coordinator, before form can be filed in chart. Administrator, [redacted] will audit all charts for next 6 months and then quarterly if not errors found.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/27/2023)

141b1 - Annual Medical Evaluation

15. Requirements

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

Description of Violation

Resident #3's most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

See attached.
A tracker from DME's and ADME's was created by Clinical Coordinator, [redacted] on 9/26/23, and it shows by what date the resident needs to have an Annual DME or ADME completed by. Audit was completed 9/26/23 by Clinical Coordinator, [redacted], and all are current with their DME's.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/27/2023)

162c - Menus Posted

16. Requirements

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

Description of Violation

The home's menu for the week of September 10, 2023 is posted. However, the weekly menu for one week in advance is not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

On 9/11/23 2 weeks worth of current menus were posted in the Personal Care dining room, where one week was previously missing. This was done by dining staff. Menus are now sent to Administrator, [redacted] weekly, so if a menu goes missing Administrator can print a new one and post right away. On 9/26/23 all Personal Care staff was education on 162.c violation, by Administrator, [redacted] and were educated on if a menu is missing to notify Administrator as soon as possible so a new can be printed and posted. The Administrator will check also on daily basis and mark off on audit sheet that menus are present. This audit will be added to the QAPI meeting report starting on 10/19/23, by the Administrator.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented ([redacted] - 11/27/2023)

183d - Prescription Current

17. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted], [redacted] prescribed for Resident #2, was found in the home's medication cart; however, the medication was prescribed once daily for seven days on [redacted] and should have been discontinued.

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

See attached.
Cart audits are to be performed by Clinical Coordinator,[redacted], monthly while we wait for an audit schedule from Phoebe Pharmacy, who will be doing monthly medication cart audits, which are to start 10/23, just waiting on specific dates. The [redacted] was removed from cart on 9/7/23 and disposed of by Administrator, [redacted] and Clinical Coordinator [redacted] on 9/7/23. On 9/26/23 staff was education on the violation 183.d, by Administrator [redacted] and Clinical Coordinator,[redacted]. When a discontinue order is received, Clinical Coordinator, [redacted] will double check the medication cart to make sure medication has been removed and that it is being returned to Pharmacy.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/27/2023)

224a - Preadmission Screen Form

18. Requirements

2600.

224a - Preadmission Screen Form *(continued)*

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 #1 was admitted to the home on [redacted]; however, there is no record of a preadmission screening form being completed for this resident.

Resident #2 was admitted to the home on [redacted]; however, there is no record of a preadmission screening form being completed for this resident.

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

See attached.
Prescreen form completion was added to the PC/AL admission checklist and will be completed by either Administrator [redacted] or Clinical Coordinator [redacted]. Admission Coordinator was educated on 224.a on 9/25/23 and that if form is not completed prior to admission that Administrator, [redacted] or Clinical Coordinator, [redacted] will complete on Admission. Audit for Pre Screens was done and completed on 10/4/23 by Administrator, [redacted]. Administrator will review all admission checklists for Personal Care to ensure that all paperwork is included and complete. Checklist was put into service on 10/2/23, by Administrator [redacted]. If a pre screen is missing on admission, one will be completed at that time by the Administrator [redacted] or the Clinical Coordinator, [redacted].

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented [redacted] - 11/27/2023)

225a - Assessment 15 Days

19. 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

An initial assessment was not completed for Resident #1, who was admitted to the home on [redacted].

Resident # 2 was admitted to the home on [redacted]. However, the only assessment in the resident's file is dated [redacted]

Resident # 3 was admitted to the home on [redacted]. However, the only assessments in the resident's file are dated [redacted] and [redacted]

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

Clinical Coordinator, [redacted] set reminder on calendar as to when the 15 day assessment needs to be completed, to ensure that they are completed within the first 15 days. Resident #1 had her initial assessment done on 9/6/23 by Clinical Coordinator, [redacted]. Regulation 225.a was reviewed with Clinical Coordinator and Administrator, Denise Geib will review all 15 day Assessments to ensure assessments are completed.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented ([redacted] - 11/27/2023)

225c - Additional Assessment

20. Requirements

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

Description of Violation

Resident #3's current assessment was completed on [redacted]. However, the Resident's previous assessment was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

See attached.
A tracker from DME's and ADME's was created by Clinical Coordinator, [redacted], and it shows by what date the resident needs to have an Annual DME or ADME completed by. Audit of Personal Care charts was completed on 10/2/23 by Administrator [redacted], all current DME's are in place and completed, with no missing information. Clinical Coordinator, [redacted] was educated on 9/26/23 on regulation 255.c and Assessment tracker was created by Administrator and Clinical Coordinator. Tracking sheet will be updated after every DME update including Significant Change DME's, so the tracker stays current. Clinical coordinator will update track.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented ([redacted] - 11/27/2023)

227g -Support Plan Signatures

21. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2 participated in the development of his/her support plan on [redacted] Although the resident signed the support plan, it was not signed by the assessor, as required.

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

Resident #2 support plan was not signed by the home because the staff person that completed the support plan is no longer here to sign it. Audit was completed on [redacted], by the Administrator [redacted]. On 9/26/23 Clinical Coordinator, [redacted], was met with and educated on regulation 227.g and reviewed that accessor and resident both need to sign support plan. Administrator, [redacted], will review and initial all completed care plans to make sure all signatures have been obtained and support plans are completed accurately before support plans are filed in chart, starting 10/2/23. Results will be added to report for QAPI meetings.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented ([redacted]/27/2023)