



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to HALCYON SENIOR LIVING LLC
LEGAL ENTITY

To operate HALCYON SENIOR LIVING
NAME OF FACILITY OR AGENCY

Located at 528 DEWEY AVENUE, BRIDGEVILLE, PA 15017
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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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 88
(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 44

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 April 16, 2024 until October 16, 2024,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **451091**

Janette Biderup
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.



CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: APRIL 16, 2024

[REDACTED]
Halcyon Senior Living LLC
528 Dewey Avenue
Bridgeville, Pennsylvania 15017

RE: Halcyon Senior Living
License/COC #: 451091

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 27, 2023, January 23, 2024, and January 29, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 451090) dated August 31, 2023 – August 31, 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); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from April 16, 2024 to October 16, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 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 X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
Section:					

183(d)	II	52	\$5	\$260	5 calendar days from mailing date of this letter
187(d)	II	52	\$5	\$260	5 calendar days from mailing date of this letter
225(a)	II	52	\$5	\$260	5 calendar days from mailing date of this letter
23(a)	II	52	\$5	\$260	5 calendar days from mailing date of this letter
187(b)	II	52	\$5	\$260	5 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide

to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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

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

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

Cc: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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

Facility Information

Name: *HALCYON SENIOR LIVING* License #: *45109* License Expiration: *08/31/2024*
Address: *528 DEWEY AVENUE, BRIDGEVILLE, PA 15017*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *HALCYON SENIOR LIVING LLC*
Address: *528 DEWEY AVENUE, BRIDGEVILLE, PA, 15017*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: <i>C-2 LP</i>	Date: <i>04/13/1998</i>	Issued By: <i>Dept L&I</i>
Type: <i>I-1</i>	Date: <i>10/23/2014</i>	Issued By: <i>Municipality of Bridgeville</i>
Type: <i>I-2</i>	Date: <i>08/03/2020</i>	Issued By: <i>Bridgeville Borough</i>

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *83* Waking Staff: *62*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *11/27/2023*

Inspection Dates and Department Representative

11/27/2023 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *88* Residents Served: *51*

Secured Dementia Care Unit

In Home: *Yes* Area: *2nd floor* Capacity: *44* Residents Served: *19*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: <i>0</i>	Are 60 Years of Age or Older: <i>51</i>
Diagnosed with Mental Illness: <i>1</i>	Diagnosed with Intellectual Disability: <i>1</i>
Have Mobility Need: <i>32</i>	Have Physical Disability: <i>1</i>

Inspections / Reviews

11/27/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/23/2023*

01/02/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *01/16/2024*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/09/2024*

01/09/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *01/16/2024*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *01/16/2024*

03/14/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: *01/16/2024*
Reviewer: [REDACTED] Follow-Up Type: *Exception*

25a - Written Contract and Review

1. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident’s designated person if any, prior to signature.

Description of Violation

Resident #1, admitted [redacted] 23, did not have a resident-home contract completed until 3/22/23.

Plan of Correction

Accept [redacted] - 01/09/2024)

Observed contract not signed for resident#1. [redacted] audited all charts confirming compliance for 2600.25.a. [redacted] office manager will audit resident contract within 24 hours after admission to Halcyon Senior Living for all admissions for the next 3 months.

Proposed Overall Completion Date: 03/31/2024

Licensee's Proposed Overall Completion Date: 03/31/2024

Implemented [redacted] 03/14/2024)

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

Resident #2's resident-home contract, dated 1/30/23, is not signed by the resident.

Plan of Correction

Accept ([redacted] - 01/09/2024)

[redacted] PCHA observed Resident #2 contact not signed by the resident. Immediately, [redacted] PCHA obtained signatures for resident #2 on 12/20. [redacted] will audit all current resident contracts on 12/15 to observe for any additional errors with contracts. Will note any out of compliance contracts. Will note any errors. Future compliance of 2600.25.b. will be completed by [redacted] or [redacted] office administrator, auditing for compliance will occur day of admission and 1 week following all new admissions for the next 3 months.

Licensee's Proposed Overall Completion Date: 03/31/2024

Implemented ([redacted] 03/14/2024)

26a - Quality Management Plan

3. Requirements

2600.

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

Description of Violation

The home did not implement its quality management plan at its most recent meeting on 9/11/23.

Plan of Correction

Accept [redacted] 01/02/2024)

Observed QA plan dated for 9/11/23, observed errors in implementation. Reviewed QAPI plan to make sure that required elements exist. Plan to follow QUPI plan every 3 months and adjust delivery of care as indicated in QA plan. [redacted] PCHA will lead QA plan with heads of departmens, clinical, maintenance, recreation, dietary which

26a - Quality Management Plan (continued)

findings to be documented in QA tool. First meeting to be held week of 1/1/24

Licensee's Proposed Overall Completion Date: 01/05/2024

Implemented (██████) 03/14/2024)

63a - First Aid/CPR Training

4. 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 11/14/23, from 11:00 p.m. - 7:00 a.m., there were 47 residents present in the home; however, there were no staff persons present in the home who were certified in first aid, obstructed airway techniques and CPR.

On 11/23/23, from 11:00 p.m. - 7:00 a.m., there were 48 residents present in the home; however, there were no staff persons present in the home who were certified in first aid, obstructed airway techniques and CPR.

Plan of Correction

Accept (██████) 01/09/2024)

See attached. ██████ reviewed all employee files and scheduled CPR course. ██████ audited employee files and noting any expired CPR cards . Scheduled CPR class on 12/12/2023 by ██████ for 14 employees. Moving forward, employee CPR will be monitored 1x/month for 6 months by ██████ or ██████ office management to ensure compliance with 2600.63.a. ██████ office manager will develop schedule for staffing to ensure a 50/1 ratio of residents/staff, starting 12/18/23. CPR courses to be offered to direct care staffing as needed

Licensee's Proposed Overall Completion Date: 06/30/2024

Implemented (██████) 03/14/2024)

65a - FS Orientation 1st Day

5. Requirements

2600.

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

- 5. The location and use of fire extinguishers.

Description of Violation

Staff person A, whose first day of work was ██████/22, did not receive orientation on the location and use of fire extinguishers.

Staff person B, whose first day of work was ██████/23, did not receive orientation on the location and use of fire extinguishers.

Staff person C, whose first day of work was ██████/23, did not receive orientation on the location and use of fire extinguishers.

Plan of Correction

Directed (██████) 01/09/2024)

██████ CHA, checked every new hire education and observed compliant and non-compliant charts. ██████

65a - FS Orientation 1st Day (continued)

Audited current forms, and noted current orientation form out of compliance with 2600.65.a. [REDACTED] PCHA made a change to the orientation form to include "location and use of fire extinguishers to ensure compliance with 2600.65.a. on 12/10/23. This form will be monitored/audited by [REDACTED] business manager prior to end of orientation onboarding day for the next 3 months

Proposed Overall Completion Date: 03/31/2024

DIRECTED

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons cited in the violation on the location and use of fire extinguishers. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 1/9/24 [REDACTED]

Directed Completion Date: 01/14/2024

Implemented [REDACTED] 03/14/2024)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.

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

- 4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A, hired [REDACTED] 22, completed [REDACTED] 40th scheduled work hour. However, this staff person did not complete training in reporting of reportable incidents and conditions.

Staff person B, hired [REDACTED] 23, completed [REDACTED] 40th scheduled work hour. However, this staff person did not complete training in reporting of reportable incidents and conditions.

Staff person C, hired [REDACTED] 23, completed [REDACTED] 40th scheduled work hour. However, this staff person did not complete training in reporting of reportable incidents and conditions.

Staff person D, hired [REDACTED] 20, completed [REDACTED] 40th scheduled work hour. However, this staff person did not complete training in reporting of reportable incidents and conditions.

Plan of Correction

Accept [REDACTED] 01/09/2024)

[REDACTED] PCHA, checked every new hire education and observed compliant and non-compliant charts. Audited current forms, and noted current orientation form out of compliance with 2600.65.b.4. [REDACTED] PCHA developed new orientation form to address violation of 2600.65.b.4. on 12/11/23. Completed training on "Reporting of reportable incidents and conditions" with staff and noted addendum orientation packet on current employees. New orientation packet for new employees to have correct requirements of 2600.65.b.4. This will be monitored/audited by the end of the orientation by Lisa Mackey on each new employee for the next 3 months

Licensee's Proposed Overall Completion Date: 03/31/2024

Implemented [REDACTED] 03/14/2024)

65g - Annual Training Content

7. 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:
 - 2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
 - 3. Resident rights.
 - 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
 - 5. Falls and accident prevention.

Description of Violation

Ancillary staff person D, hired [REDACTED] 20, did not receive training in resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, and emergency preparedness procedures and recognition and response to crises and emergency situations during training year in 2022.

Plan of Correction

Accept [REDACTED] 01/09/2024)

[REDACTED] PCHA observed violation of 65.g.2-5. [REDACTED] PCHA completed the training with staff person D on 1/8/24 on "Older Adults Protective Series Act), falls and accident prevention and emergency preparedness procedures and recognition and response to crises and emergency situations." Full audit of g5.g.2-5 to be completed and finalized by 1/31/24. Trainings on 65.g.2-5 to be completed and documented during 2/20/24 staff training. [REDACTED] office manager will audit begin audit on 1/2/24, 1 time per week, on employee files by 3/31/24. [REDACTED] will observe that annual training to be completed/signed/ and that the content of training will coincide with 2600.65g

Licensee's Proposed Overall Completion Date: 03/31/2024

Implemented ([REDACTED] - 03/14/2024)

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 second floor nurses station did not include eye coverings and a breathing shield.

Plan of Correction

Accept ([REDACTED] - 01/02/2024)

Reviewed contents of 2nd floor first aid kit and observed missing eye coverings and breathing shield. Audited both 1st and 2nd floor first aid kits. Replaced eye coverings and breathing shield in 2nd floor kit by [REDACTED] DON, photo recorded and attached. First Aid kits to be audited by [REDACTED] or [REDACTED] PCHA in 3 months to ensure compliance

Licensee's Proposed Overall Completion Date: 03/31/2024

Implemented ([REDACTED] - 03/14/2024)

100a - Exterior - Free of Hazards

9. Requirements

2600.

- 100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

At 1:06 p.m., the handle to the gate in the far right corner of the courtyard was missing, and the gate was unable to be opened.

100a - Exterior - Free of Hazards (continued)

Plan of Correction Accept (██████ 01/02/2024)

██████ PCHA and ██████ maintenance director observed non functioning locking mechanism on gate in front right corner on 12/13/23. ██████ reviewed other gates within courtyard to ensure functionality. new lock purchased, installed as noted in photo attached by ██████ will review gait locking mechanics 1x/month for 1 year to maintain proper functionality

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented ██████ 03/14/2024)

102i - Soap Dispenser

10. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

At 10:20 a.m., there were 2 unlabeled bars of soap in the shower stall in the common first floor shower room.

Plan of Correction Accept ██████ - 01/02/2024)

Removal of soap bars noted in bathroom. ██████ and ██████ audited other bathrooms within facility for compliance of 102.i. Will review with staff importance of proper management of 102.i during next staff meeting on 12/27/23. ██████ will audit bathrooms for compliance of 102i 1x/week for 6 weeks, noting compliance.

Licensee's Proposed Overall Completion Date: 02/01/2024

Implemented ██████ 03/14/2024)

109a - Pets

11. Requirements

2600.

109.a. The home rules shall specify whether the home permits pets on the premises.

Description of Violation

The home rules do not specify whether the home permits pets on the premises; however, there are multiple pets that visit the home.

Plan of Correction Accept ██████ - 01/02/2024)

██████ PCHA reviewed current house rules. Observed that allocation of pets was not included on House Rules of Halcyon Senior Living. Will make change of house rules, posted change of house rules on 2/1/24 giving 30 day notice as item attached with date of 1/2/24

Licensee's Proposed Overall Completion Date: 02/01/2024

Implemented ██████ 03/14/2024)

123b - Emergency Procedures Posted

12. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

123b - Emergency Procedures Posted (*continued*)**Description of Violation**

At 9:28 a.m., the home's emergency procedures were in the office behind the front desk and not posted in a public and conspicuous place.

Plan of Correction

Accept (████ - 01/02/2024)

████ PCHA immediately moved binder to public and conspicuous location. █████ reviewed RCG on placement of location of emergency binder with █████ office manager. Placed binder on front desk with photo attached. █████ will review placement of binder 1x/week for 6 weeks to ensure compliance starting 12/18/13

Licensee's Proposed Overall Completion Date: 02/01/2024

Implemented (████ - 03/14/2024)

132f - Alternate Exit Routes

13. Requirements

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

During the fire drills held monthly from 11/15/22 through 10/30/23, the only exit route indicated is "beyond fire doors."

Plan of Correction

Accept (████ - 01/09/2024)

████ observed documentation of fire drills from 11/15/22 to 10/30/23 not completing alternate exit routes. Reviewed policy with █████, maintenance, █████, █████, Director of Nursing. Within next planned fire drill, plan on using alternate exit routes including use of exit egress by blocking exit, simulating an additional emergency, this will be documented in our fire drill log. This process will start on Jan 1, 2024 and █████ will monitor/document the change being made during the fire drill to ensure alternate exit route, documented in our fire drill log. █████ PCHA will monitor/audit the log once a month over the next 6 months.

Licensee's Proposed Overall Completion Date: 06/30/2024

Implemented (████ - 03/14/2024)

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.

141a 1-10 Medical Evaluation Information (continued)

Description of Violation

Resident #1's initial medical evaluation, dated [REDACTED]/23, does not include the resident's pulse rate. This area of the form is blank.

REPEAT VIOLATION: 4/4/2022 et al.

Plan of Correction

Accept [REDACTED] 01/09/2024)

[REDACTED] PCHA observed repeated violation of 141.a.1-10 on medical chart #1. [REDACTED] then obtained pulse rate from noted resident and documented not the DME on 1/2/24. [REDACTED] audited all DME at the facility noting other charts out of compliance with 141.a. This audit was completed on 12/15. By 1/1/24, [REDACTED] will make sure that all pulse rates are completed in the DME as well as other areas within the DME form. Future audits will be completed by [REDACTED] administrator or [REDACTED] office manager 1x/quarter for 1 year to ensure compliance

Licensee's Proposed Overall Completion Date: 12/31/2024

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 was admitted to the secure dementia care unit (SDCU) on [REDACTED]/22; however, the resident's most recent medical evaluation, dated 2/14/23, does not indicate a diagnosis of Alzheimer's disease or other dementia.

Resident #4's most recent medical evaluation, dated 10/17/23, does not indicate the resident's height. This area of the form is blank.

Plan of Correction

Accept [REDACTED] - 01/09/2024)

[REDACTED] PCHA, and [REDACTED] observed charts for residents #3 and #4 observing violations. [REDACTED] immediately obtained resident height for resident #4 on 12/16/23 and updated record. [REDACTED] also was able to update medical record to include dementia diagnosis on 12/16/23. [REDACTED] audited all medical charts on between the dates of 12-14 and 12-15 noting areas of non-compliance with 141.b.1. [REDACTED] will be correcting all errors noted in annual medical evaluation and taking corrective actions, gathering objective data, ensuring that documentation within the progress notes from MD match the diagnosis on the annual medical evaluation. Every chart will be in compliance by 1/31/24. [REDACTED] office manager will complete audits of documentation 1x/6months to ensure that proper documentation matching MD documentation

Licensee's Proposed Overall Completion Date: 06/30/2024

161d - Dietary Needs

16. Requirements

2600.

161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On 11/14/23, resident #5 was prescribed a pureed diet with honey thickened liquids. However, the resident regularly requests and is served peanut butter and jelly sandwiches for lunch and dinner.

161d - Dietary Needs (continued)

Plan of Correction

Directed [redacted] 01/09/2024)

[redacted] observed violation of 161.d. within resident #5 chart. Audited all charts and dietary restrictions on 12/15, completed by [redacted] PCHA and [redacted] DON. Educated patient on importance of following MD prescribed diet modification and special dietary needs, which resident refused to comply. Notified MD on Friday 12/15/23, which pt continued to refuse, demanding peanut butter and jelly sandwiches, which documented requests. During February staff educational sessions, Date 2/28/23, all staff review 2600.161(D) and the specific residents who have specific dietary restrictions. This will be completed by [redacted] DON. Audit moving forward will consist of observing for errors in diet modification and medical documentation, and special dietary needs and the actual meals/drinks being served to residents. This to be completed by [redacted] for 1 every 2 weeks for 3 months, starting 1/1/24 Halcyon Senior Living will only provide residents with the diet designated by a medical professional.

Proposed Overall Completion Date: 03/31/2024

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the home does not provide any resident with meals or food items that are outside of the prescribed dietary restrictions. 1/9/24 [redacted]

Directed Completion Date: 01/10/2024

Not Implemented ([redacted] 3/14 [redacted])

162c - Menus Posted

17. 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

At 9:23 a.m., the home's menu posted in the dining room ended on 12/2/23. The following week's menu was not posted.

Plan of Correction

Accept [redacted] 01/09/2024)

[redacted] observed that home's menu not posted with following week to keep compliance of 162.c, speaking with [redacted] dietary manager. Immediately, [redacted] PCHA placed a menu of 1 week advance on 11/27/23. Educated on compliance of 162.c. Printed and placed 2nd week menu on 12/4/23. Moving forward, every Sat, new menu to be placed for visual view for subsequent week, and Monday, previous weeks menu will be removed, this to be monitored by [redacted] for 3 weeks

Licensee's Proposed Overall Completion Date: 01/31/2024

Implemented [redacted] 03/14/2024)

183d - Prescription Current

18. 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

Furosemide 20mg, prescribed for resident #3, was in the home's SDCU medication cart; however, the medication was

183d - Prescription Current (continued)

discontinued on 10/3/23.

The following discontinued medications, prescribed for resident #5, were in the home's SDCU medication cart:

- polyethylene glycol 3350, discontinued 11/17/23
- acetaminophen 500mg, discontinued 11/24/23

REPEAT VIOLATION: 7/26/2022 et al.

Plan of Correction

Accept [REDACTED] - 01/02/2024)

[REDACTED] PCHA and [REDACTED] DON reviewed the description of the violation SDCU medications and disposed properly of the medications . Completed med cart audit by [REDACTED] DON, removing any other DC'd meds, completed on 12/18. At Jan staff meeting, will complete training on proper identification of DC'd medications and disposal. [REDACTED] office manager will complete medication cart audit every month for 6 months.

Licensee's Proposed Overall Completion Date: 06/30/2024

185a - Implement Storage Procedures

19. Requirements

2600.

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

Description of Violation

On 11/22/23 at 5:20 p.m., resident #1's glucometer indicated a blood sugar reading of 186; however, the resident's medication administration record (MAR) indicates a blood sugar reading of 169.

Resident #3 is prescribed lidocaine 2% Viscous 100ml MGP-Swish and swallow 10ml by mouth every 6 hours as needed for pain; however, the medication was not available in the home.

REPEAT VIOLATION: 7/26/2022 et al.

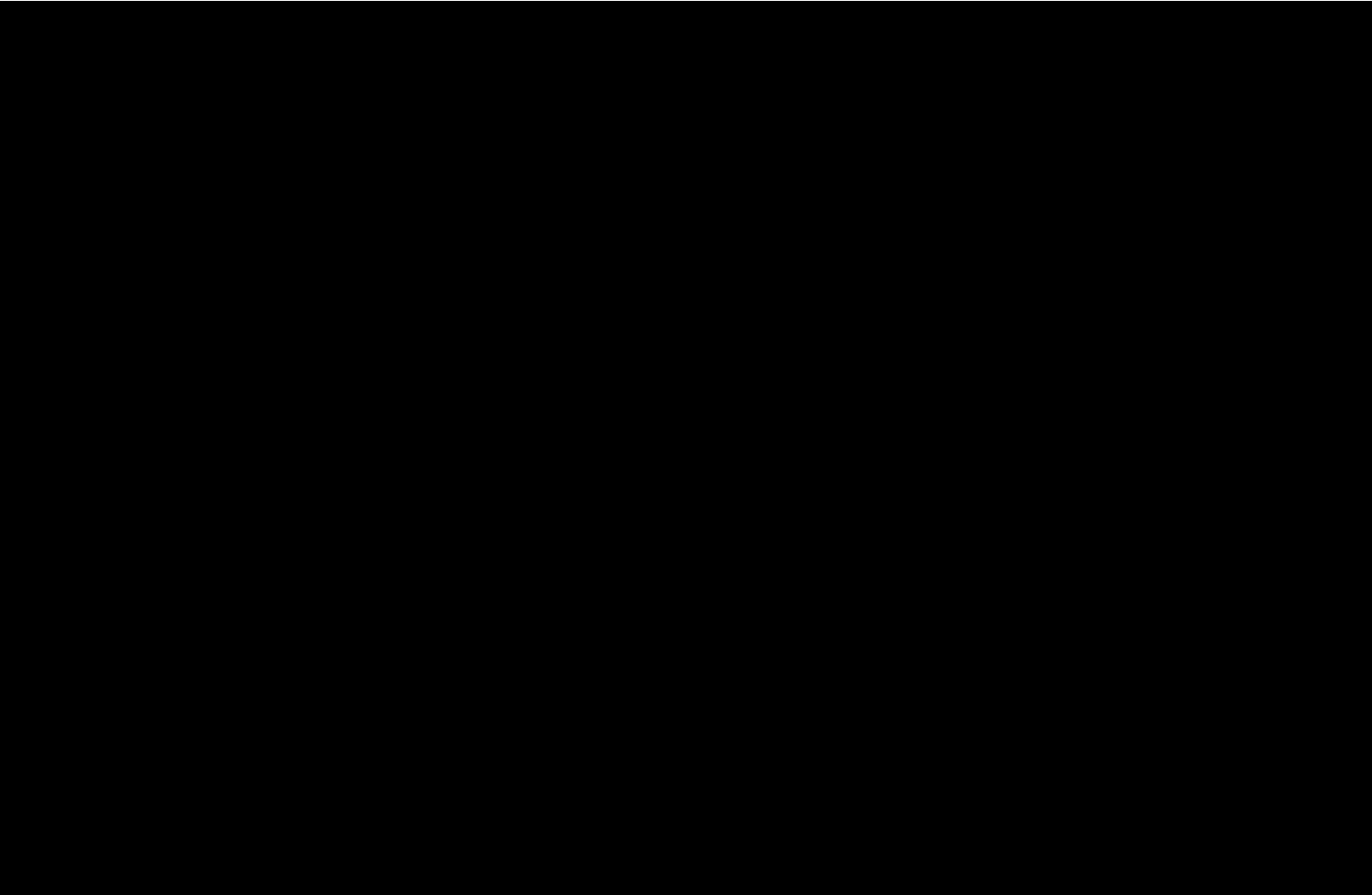
Plan of Correction

Accept [REDACTED] - 01/09/2024)

[REDACTED] DON, observed glucometer reading to observe incorrect reading/documentation. Observed that there was a missing medication/contacted pharmacy. [REDACTED] DON will complete audit on all glucometers by 1/15/23, noting any errors; complete med cart audit to be completed by 12/31/23. By 3/1/24 diabetic training to be conducted with all med techs within building to ensure compliance. Will discuss 2600.185(a) with staff at meeting on 1/25/24, implementation on 1/26/24. 185.a. [REDACTED] DON will audit glucometers 1x/month for 6 months. Med cart audit to be performed by [REDACTED] DON 1x/month for 6 months starting 1/2/24. [REDACTED] DON completed medication reconciliation on resident #3, Medical provider contacted and DC order for PRN lidocaine obtained On 11/28/23 due to resident not using/requesting PRN.

Licensee's Proposed Overall Completion Date: 03/31/2024

Not Implemented (JK-3/14/24)



224a - Preadmission Screen Form

21. 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] 5/23, does not include the resident's ability to safely use and avoid poisonous materials.

REPEAT VIOLATION: 10/28/2022

Plan of Correction

Accept [REDACTED] 01/09/2024)

[REDACTED], PCHA observed violation of resident #5 missing "ability to safely use and avoid poisonous material". [REDACTED] immediately updated the prescreen admission form with the correct details, selecting unable to avoid poisonous materials on 12/16/23. [REDACTED] audited all current residents pre-admission forms to ensure compliance of 224.a., noting areas of non-compliance. [REDACTED] corrected any part of the pre-admission form as of 12/18 and documented "up to date" on PCHA audit form. [REDACTED] office administrator will review new residents and their pre-admission form prior to admission to ensure compliance for 6 weeks

Licensee's Proposed Overall Completion Date: 02/29/2024

Not Implemented [REDACTED] 03/14/2024)

225a - Assessment 15 Days

22. Requirements

2600.

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

Description of Violation

Resident #2’s initial assessment, dated [REDACTED] 23, does not include the care and services required for multiple diagnoses, including the following, as indicated on the resident's medical evaluation dated 1/23/23:

- Right femur and radius fractures
- unsteadiness on feet
- muscle weakness
- dysphagia
- cognitive communication deficit
- osteoporosis
- aFIB
- TIA

REPEAT VIOLATION: 9/13/2022 et al.; 4/4/2022 et al.

Plan of Correction

Accept [REDACTED] - 01/09/2024)

[REDACTED] PCHA and [REDACTED] DON observe chart on resident #2 initial assessment. [REDACTED] immediately corrected the documentation to include correct diagnosis for resident #2 on 12/18/23. [REDACTED] audited all medical charts and made corrective changes as indicated. Complete and updated medical chart audit and correction will be completed by [REDACTED] by 1/31/24. [REDACTED] they will audit charts for compliance 1x/6 months to ensure compliance

Licensee's Proposed Overall Completion Date: 06/30/2024

225c - Additional Assessment

23. Requirements

2600.

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

1. Annually.

Description of Violation

Resident #3’s most recent assessment, dated [REDACTED] 23, indicates the resident requires moderate mobility assistance; however, the resident requires total assistance of 2 staff persons for mobility. In addition, the resident’s assessment indicates [REDACTED] requires moderate supervision; however, the resident resides in the SCDU and requires extensive supervision.

Plan of Correction

Accept [REDACTED] - 01/02/2024)

[REDACTED] PCHA observed violation of 225.c. on resident #3 and [REDACTED] updated in documentation on 12/20. [REDACTED] audited mobility list making any changes necessary to be in compliance with SCDU. [REDACTED] [REDACTED] to complete a full audit of SCDU and PC floors to make sure that mobility levels are reflective of each residents mobility status by 1/31/24. [REDACTED] office manager will complete audits of mobility status 1x/6months

Licensee's Proposed Overall Completion Date: 06/30/2024

227g -Support Plan Signatures

24. 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 #5's most recent support plan, dated [redacted]/23, is not signed by the resident, and the home did not make a notation regarding the resident's ability to sign.

REPEAT VIOLATION: 10/28/2022

Plan of Correction

Accept ([redacted] 01/02/2024)

[redacted] PCHA observed violation of 227g. and corrected document for resident #5 and obtained approved signature. [redacted] office manager to complete audit on all RASPs and upate signatures as indicated by 1/31/24. Obtaining signatures or noting unavailability to sign to be completed alongside audit. Signatures on RASPs to be audited by [redacted] to be completed in 6 months

Licensee's Proposed Overall Completion Date: 06/30/2024

Implemented ([redacted] - 03/14/2024)

231g - Non-Dementia Admission

25. Requirements

2600.

231.g. An individual who does not have a primary diagnosis of Alzheimer’s disease or other dementia may reside in the secured dementia care unit if desired by the resident.

3. The individual shall have access to and be able to follow directions for the operation of the key pads or other lock-releasing devices to exit the secured dementia care unit.

Description of Violation

Resident #5, who does not have a primary diagnosis of Alzheimer’s disease or other dementia, resides in the SDCU; however, the resident cannot independently operate the locking mechanism to exit the secure dementia unit.

Plan of Correction

Accept ([redacted] 01/09/2024)

[redacted] PCHA, observed medical charting and compared it to up to date EHR. [redacted] RN, DON, updated patients chart on 12/27/23 by including dementia related diagnosis, which was previously documented, but not added to [redacted] medical history within our EHR. Audit performed on all SDU confirming Alzheimers/cog impairment dx. Confirmed by [redacted] that all medical charts up to date within EHR. [redacted] or [redacted] office management will audit DX on DME/RASP 1 week after admission to SDU for 3 months.

Licensee's Proposed Overall Completion Date: 03/31/2024

Implemented ([redacted] - 03/14/2024)

252 - Record Content

27. Requirements

2600.

252. Content of Resident Records - Each resident’s record must include the following information:

3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #4's record includes a photograph of the resident, dated [redacted]/21, which is greater than 2 years old.

252 - Record Content (*continued*)**Plan of Correction****Accept** [REDACTED] - 01/02/2024)

[REDACTED] PCHA, immediately reviewed resident #4 chart and observed date taken. Then audited all current residents photos/dates as described in 2600.252.3. Any photo that was outdated was replaced with the corrected and re-printed from the EHR system. [REDACTED] /office management will audit photos 1x/year and note/change photo as indicated

Licensee's Proposed Overall Completion Date: 12/31/2023**Implemented** [REDACTED] 03/14/2024)

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

Facility Information

Name: *HALCYON SENIOR LIVING* License #: *45109* License Expiration: *08/31/2024*
Address: *528 DEWEY AVENUE, BRIDGEVILLE, PA 15017*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] *DPT PCHA* Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *HALCYON SENIOR LIVING LLC*
Address: *528 DEWEY AVENUE, BRIDGEVILLE, PA, 15017*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: <i>C-2 LP</i>	Date: <i>04/13/1998</i>	Issued By: <i>Dept L&I</i>
Type: <i>I-1</i>	Date: <i>10/23/2014</i>	Issued By: <i>Municipality of Bridgeville</i>
Type: <i>I-2</i>	Date: <i>08/03/2020</i>	Issued By: <i>Bridgeville Borough</i>

Staffing Hours

Resident Support Staff: Total Daily Staff: *82* Waking Staff: *62*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Incident, Interim* Exit Conference Date: *01/29/2024*

Inspection Dates and Department Representative

01/23/2024 - On-Site: [REDACTED]
01/29/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity: <i>88</i>		Residents Served: <i>52</i>	
Secured Dementia Care Unit			
In Home: <i>Yes</i>	Area: <i>2nd Floor</i>	Capacity: <i>44</i>	Residents Served: <i>19</i>
Hospice			
Current Residents: <i>3</i>			
Number of Residents Who:			
Receive Supplemental Security Income: <i>0</i>		Are 60 Years of Age or Older: <i>52</i>	
Diagnosed with Mental Illness: <i>1</i>		Diagnosed with Intellectual Disability: <i>0</i>	
Have Mobility Need: <i>30</i>		Have Physical Disability: <i>0</i>	

Inspections / Reviews

01/23/2024 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *02/19/2024*

02/23/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *03/11/2024*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *03/01/2024*

03/04/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *03/11/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *03/11/2024*

03/14/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *03/11/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

23a - Activities of Daily Living Assistance

1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's assessment, dated [redacted] 24, indicates the resident requires physical assistance with personal hygiene; and the resident's support plan, dated [redacted] 5/24, indicates direct care staff will have all needed supplies available, and the resident will be assisted by staff with what [redacted] is unable to do. However, on 1/23/24, the resident's nails were excessively long with a dark brown substance caked under his nails, resulting in scratches on resident #2's wrist when resident #1 grabbed [redacted] on [redacted] 24.

REPEAT VIOLATION: 10/28/2022

Plan of Correction

Accept ([redacted] - 03/04/2024)

On 1/27/24, Resident #1 was agreeable to having proper hygiene activities including cutting of fingernails. DON spoke with resident #1 family regarding proper hygiene and house rules relating to best hygiene practices.

DON and clinical staffing will monitor all resident fingernails and provide proper hygiene care as noted within the resident support plan within 1 week

Education on staff on hand hygiene is slated to be completed for 2/14/24 @ 2pm. Attached is Halcyon Senior Living Policy for hand hygiene.

weekly nail care applied to the MAR

As of week of 2/25/24, Administrator will complete private interviews of at least three residents a week for three month and three residents a month by the administrator to ensure compliance with Regulation 2600.23(a). Created an interview questionnaire and maintaining the documentation in the home.

2/19/24

Licensee's Proposed Overall Completion Date: 03/01/2024

Not Implemented ([redacted] -3/14/24)

85a - Sanitary Conditions

2. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/23/24 at 10:20 a.m., there were 3 used washcloths and an unlabeled hairbrush in the shared bathroom between rooms #210 and #212 in the Secure Dementia Care Unit (SDCU).

Plan of Correction

Accept ([redacted] - 02/22/2024)

Immediately removed indicated washcloths and personal items on 1/23/24

All shared bathroom spaces audited for the presence of personal items, attached is audit tool for addressing 85.a.

85a - Sanitary Conditions (continued)

Dispensers purchased for soap/shampoo/body wash for central showers- will be delivered 2/14. Moving forward, a shower audit spot on the CNA/CMT daily sheets to check the showers. Staff to be education on infection control and the need to keep ALL personal items out of the shower when finished using on 2/14/24

Daily sheets will be audited daily during morning meeting for the next 30 days

2/19/2024

Licensee's Proposed Overall Completion Date: 02/19/2024

Implemented [redacted] - 03/14/2024)

141a 1-10 Medical Evaluation Information

3. 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

On 1/23/24, resident #3's initial medical evaluation, dated [redacted]23, indicated "see attached" in the medication addendum section; however, nothing was attached. On 1/29/24, there was a medication list, dated 6/15/23, printed and attached to the medical evaluation on [redacted]24. However, there was no indication that the medical professional who performed the evaluation was contacted and gave permission to correct the medical evaluation.

Plan of Correction

Accept [redacted] - 03/04/2024)

Physician was contacted immediately and informed of the updated information on the DME.

Admin checked each resident that had corrected DME, documenting corrected errors with date/times/person spoken to

All DME modifications requests to come to Admin in writing. Admin will ensure that DME is corrected and verify that physician has been updated on the need for correction. Form to be used requesting corrected information. Include form in POC in Sanswrite. Education provided to clinical staff on the procedure going forward on 2/14/24

ALL DMEs will be audited for completion and correctness by DON AND Admin within 24 hours of admission.

141a 1-10 Medical Evaluation Information (continued)

All new residents and their DMEs will be audited by Administrator or directed personal within 24 hours of admission for the next 3 months. All current residents DMEs and will be audited within one week by Administrator to ensure compliance of 141.a.1. Newly created DMEs will be audited by Administrator for 3 months. Audit tool attached

2/19/2024

Licensee's Proposed Overall Completion Date: 03/01/2024

Not Implemented [redacted]-3/14/24)

141b2 - Medical Evaluation Changes

4. Requirements

2600.

141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #1's most recent medical evaluation, dated [redacted]23, was updated by staff person A on [redacted]/24 in the areas of weight, pulse rate, blood pressure, and temperature; however, there was no indication that the medical professional who performed the evaluation was contacted and gave permission to correct the medical evaluation.

On 1/23/24, resident #4's most recent medical evaluation, dated [redacted]/23, did not indicate the evaluation type, allergies, or health status. These areas of the form were blank. On 1/26/24, the medical evaluation was updated by staff person A to indicate an evaluation type of status change, NA for allergies, and a health status of poor ; however, there was no indication that the medical professional who performed the evaluation was contacted and gave permission to correct the medical evaluation.

Plan of Correction

Accept ([redacted] - 03/04/2024)

Physician was notified of the updates to Resident #1 and Resident #4 DME.

Checked each resident for correct DME, corrections to DME made with person spoke to/date/time

All DME modifications requests to come to Admin in writing. Admin will ensure that DME is corrected and verify that physician has been updated on the need for correction. A form to be used requesting corrected information, include a signature line for Admin and one for physician. Education provided to clinical staff on the procedure going forward.

ALL DMEs will be audited for completion and correctness by DON AND Admin within 24 hours of admission.

All new residents and their DMEs will be audited by Administrator or directed personal within 24 hours of admission for the next 3 months. All current residents DMEs and will be audited within one week by Administrator to ensure compliance of 141.a.1. Newly created DMEs will be audited by Administrator for 3 months. Audit tool attached

2/19/2024

Licensee's Proposed Overall Completion Date: 05/01/2024

Implemented [redacted] 03/14/2024)

161d - Dietary Needs

5. Requirements

161d - Dietary Needs (continued)

2600.

161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On 12/6/23, resident #5 was ordered a mechanical soft diet. However, on 1/23/24 at approximately 10:10 a.m., the resident was in [redacted] bed eating a piece of buttered toast.

Plan of Correction

Accept ([redacted] 02/22/2024)

Resident #5's diet was verified to be correct and order is correct in TabulaPro

Audit all resident charts for correct diet orders. Developed a spreadsheet of all resident with indication that their orders are correct and correctly entered into Tabulapro.

Education provided to staff on the importance of following diet orders, the indications and definitions of specific consistencies on 2/14/24

Diet orders are to be printed weekly and placed in the kitchen. All diet order updates to be added to Tabulapro and new list posted in kitchen.

2/19/2024

Licensee's Proposed Overall Completion Date: 02/19/2024

Not Implemented ([redacted]-3/14/24)

183d - Prescription Current

6. 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 1/29/24, resident #6's risperidone 0.5mg was in the home's medication cart; however, the medication was discontinued on 1/9/24.

REPEAT VIOLATION: 7/26/2022 et al.

Plan of Correction

Accept ([redacted] - 03/04/2024)

Discontinued Risperidone removed from the Medication Cart.

Full cart audits completed on 2/13, 2/14

Staff educated on hte need to remove DC'd medication immediately upon receiving order on 2/14/24. Weekly med cart audits by the DON or designee.

Weekly cart audits by DON or designee

Audits to begin week of 2/11/24 for 4 weeks, then bi monthly for 4 months

2/19/2024

183d - Prescription Current *(continued)*

Licensee's Proposed Overall Completion Date: 03/08/2024

Not Implemented [REDACTED]-3/14/24)

185a - Implement Storage Procedures

7. Requirements

2600.

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

Description of Violation

On 1/29/24, resident #7's glucometer was not calibrated to the correct time.

Plan of Correction

Accept [REDACTED] 02/22/2024)

Resident #7's Glucometer was calibrated

All glucometers were audited and recalibrated to show correct date and time. Staff educated on the need to verify that glucometer date and time are correct prior to obtaining blood sugar on 2/14/24

ALL glucometers are to be checked and recalibrated weekly by DON.

2/19/2024

Licensee's Proposed Overall Completion Date: 02/19/2024

Not Implemented [REDACTED] 3/14/24)

187b - Date/Time of Medication Admin.

8. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #6's January 2024 medication administration record (MAR) indicates that the resident's Eucerine cream was administered on 1/28/24 at 8:57 a.m. and at 5:32 p.m. and on 1/29/24 at 9:11 a.m.; however, the medication was not administered because it was not available in the home.

REPEAT VIOLATION: 7/26/2022 et al.

Plan of Correction

Accept [REDACTED] 03/04/2024)

Eucerin Cream was ordered from the pharmacy and available for administration.

Audit all carts to ensure that all ordered medication is in carts and available for administration.

Staff educated(2/14/24) on the need to ensure that all orders are sent to HD, that the medications are verified and that we have received delivery of medication. DON to ensure that medications are available that all newly ordered medications are delivered by reviewing delivery log following HD delivery.

DON to review the HD Medication delivery logs to ensure that all newly ordered medications have been delivered.

Audits 1x/week for 4 weeks, then 2x/month for 4 months

187b - Date/Time of Medication Admin. (continued)

2/19/2024

Licensee's Proposed Overall Completion Date: 03/08/2024

Not Implemented [REDACTED]-3/14/24)

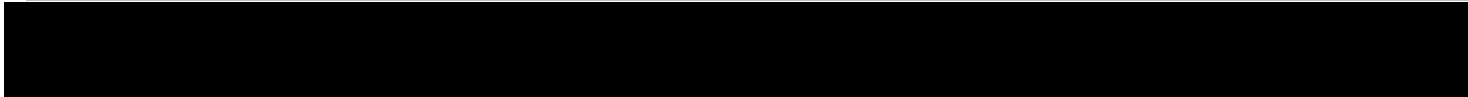
187d - Follow Prescriber's Orders

9. Requirements

2600.

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

Description of Violation



Resident #6 is ordered Eucerine cream-Apply topically to legs, arms, and back every day and evening shift; however, the medication was not administered on 1/28/24 at 8:57 a.m. and at 5:32 p.m. and on 1/29/24 at 9:11 a.m. because it was not available in the home.

REPEAT VIOLATION: 4/4/2022 et al; 7/26/2022 et al.

Plan of Correction

Directed [REDACTED] 03/04/2024)

Resident #5's diet was verified to be correct and order is correct in TabulaPro

Audit all resident charts for correct diet orders. Spreadsheet of all residents with indication that their orders are correct and correctly entered into Tabulapro.

Education provided to staff on the importance of following diet orders, the indications and definitions of specific consistencies on 2/14/24

Diet orders are to be printed weekly and placed in the kitchen. All diet order updates to be added to Tabulapro and new list posted in kitchen.

Eurcerin order received from pharmacy and placed in medication chart

Staff Education on Halcyons Policy and procedure regarding 187D, completed by DON/Administrator on 2/14/24

DON/designee to complete chart audit 1x/week for 4 weeks then 2x/month for 4 months

Notified resident designated person of the medication error on 2/27/24 by Administrator

Notified MD of med error by Administrator of 2/27. Halcyon Senior Living will follow orders followed by MD

Incident report completed

Proposed Overall Completion Date: 03/08/2024

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall document the failure to

187d - Follow Prescriber's Orders (continued)

follow the prescribers in each of the resident's permanent records. 3/4/24

Directed Completion Date: 03/08/2024

Not Implemented (-3/14/24)

225a - Assessment 15 Days

10. 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

On 12/6/23, resident #5 was ordered a mechanical soft diet. However, initial assessment, dated 23, indicates dietary need is "Needs food cut up".

REPEAT VIOLATION: 4/4/2022 et al; 9/13/2022 et al.

Plan of Correction

Directed 03/04/2024)

Resident #5's diet was verified to be correct and order is correct in TabulaPro. RASP updated to include correct diet .

Admin/DON audit all resident charts for correct diet orders. Ensured that the correct dietary needs are reflected on the RASP. Spreadsheet of all residents with indication that their orders are correct and correctly entered into Tabulapro.

Education provided to staff on the importance of following diet orders, the indications and definitions of specific consistencies and the need to have correct diet applied to the RASP on 2/14/14

As dietary orders are received, DON to monitor that the correct information is applied to the RASP.

Administrator and DON audited current resident records to ensure all residents have a complete and accurate assessment and the assessment is in the resident's record on 2/27/24

Proposed Overall Completion Date: 03/01/2024

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all newly completed assessments to ensure all residents have a complete and accurate assessment and the assessment is in the resident's record. 3/4/24

Directed Completion Date: 03/05/2024

Not Implemented (-3/14/24)

225c - Additional Assessment

11. Requirements

2600.

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

- 2. If the condition of the resident significantly changes prior to the annual assessment.

225c - Additional Assessment (continued)

Description of Violation

Resident #8's most recent medical evaluation, dated [REDACTED] 23, indicates the resident had a significant change; however, the resident's most recent assessment, dated [REDACTED] 23, was not updated.

Plan of Correction

Accept [REDACTED] 02/22/2024)

A new RASP for resident #8 was completed to reflect the significant change 4/4/23. Resident returned to HSL on 2/13; RASP/DME completed 2/14/24 to include status change

All resident DMEs/RASPs were audited to ensure that any significant changes were reflected with new DME and RASP.

Education provided to staff regarding 225C and the need to complete a new RASP following a significant change on 2/14/24

Admin/DON are to review significant changes in morning meeting and ensure that new RASP is completed.

2/19/2024

Licensee's Proposed Overall Completion Date: 02/19/2024

Not Implemented ([REDACTED] 03/14/2024)

231b - Medical Evaluation

12. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #9 was admitted to the SDCU on [REDACTED] 23; however, on [REDACTED] 24, the resident's initial medical evaluation, dated [REDACTED] 23, did not indicate the need for an SDCU. On 1/26/24, the resident's medical evaluation was updated to indicate the need for an SDCU; however, there was no indication that the medical professional who performed the evaluation was contacted and gave permission to correct the medical evaluation.

Plan of Correction

Accept [REDACTED] 02/22/2024)

Physician was contacted immediately and informed of the updated information on the DME.

Audited each resident that had corrected DME, and corrections made as needed

All DME modification requests to come to Admin in writing. Admin will ensure that DME is corrected and verify that physician has been updated on the need for correction. Form to be used requesting corrected information, include a signature line for Admin and one for physician. Include form in POC in Sanswrite. Education provided to clinical staff on the procedure going forward on 2/14/24

ALL DMEs will be audited for completion and correctness by DON AND Admin within 24 hours of admission.

Licensee's Proposed Overall Completion Date: 02/19/2024

231b - Medical Evaluation (continued)

Implemented [REDACTED] 03/14/2024)

234d - Support Plan Revision

13. Requirements

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #1, a resident in the SDCU, began receiving hospice services on 11/2/23. However, the resident's most recent support plan, dated [REDACTED] 24, does not indicate the care and services or frequency of services that are being provided by hospice.

Resident #2, a resident in the SDCU, routinely wanders into resident bedrooms and refuses to leave when asked; however, [REDACTED] wandering behavior is not addressed on [REDACTED] most recent support plan, dated 11/3/23.

Plan of Correction

Directed [REDACTED] 03/04/2024)

Updated RASP for resident # 2 to include wandering behavior

Completed RASP audit of all residents on 1/26/24 to identify any outdated information and corrected as needed

Education provided to staff on the importance of following RASP, the indications and implications of following RASP on 2/14/24. Reviewed Halcyon Policies regarding wandering including policy explanation and compliance guidelines.

To address increased wandering, reported to MD on clinical findings. Updated rasp on Resident #2 to include increased supervision by staff as noted in documentation of behavior changes, increasing interventions to increase staff awareness or risk, behavior, communication, ensure proper staffing on floor, hiring Life Enrichment Director.

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Proposed Overall Completion Date: 03/01/2024

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall remove the STOP sign placed at resident #2's door. 3/4/24 [REDACTED]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all newly completed support plans for accuracy and completeness. 3/4/24 [REDACTED]

Directed Completion Date: 03/05/2024

Implemented [REDACTED] 03/14/2024)