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

April 1, 2024

[redacted], EXECUTIVE DIRECTOR
PROVIDENCE PLACE OF POTTSVILLE ASSOCIATES
[redacted]

RE: PROVIDENCE PLACE OF POTTSVILLE
2200 FIRST AVENUE
POTTSVILLE, PA, 17901
LICENSE/COC#: 20397

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/03/2024, 01/04/2024, 01/11/2024 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *PROVIDENCE PLACE OF POTTSVILLE* **License #**: *20397* **License Expiration**: *12/05/2024*

Address: *2200 FIRST AVENUE, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *PROVIDENCE PLACE OF POTTSVILLE ASSOCIATES*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/14/2013* **Issued By**: *City of Pottsville*

Staffing Hours

Resident Support Staff: *2* **Total Daily Staff**: *204* **Waking Staff**: *153*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *01/11/2024*

Inspection Dates and Department Representative

01/03/2024 - On-Site: [redacted]
01/04/2024 - On-Site:
01/11/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *192* **Residents Served**: *143*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Connections* **Capacity**: *56* **Residents Served**: *44*

Hospice

Current Residents: *16*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *142*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *59* **Have Physical Disability**: *0*

Inspections / Reviews

01/03/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/02/2024*

Inspections / Reviews *(continued)*

02/05/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *02/08/2024*

02/12/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/17/2024*

04/01/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2024*

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

The License Inspection Summary dated 9/21/23 was not posted in the home.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1-The Executive Director was out on Maternity Leave when the inspection happened on 9/21/2023. Upon discovery of the License Inspection Summary not being posted during inspection on 1/3/2024, it was immediately posted by the Executive Director.
2- The Executive Director or Designee will complete ongoing audits beginning 2/5/2024 and continuing monthly to ensure the current License Inspection Summary is posted in a conspicuous and public place in our personal care home.

Licensee's Proposed Overall Completion Date: *02/06/2024*

Implemented [redacted] - 03/29/2024)

5a1 - DHS Access

2. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

Department Representatives requested resident records at approximately 9:30 am but did not receive the records to review until 1:55pm.

Plan of Correction ***Accept [redacted] - 02/05/2024)***

Department Managers were educated on Regulation 2600.5a.1 and will promptly give access to resident files to surveyors in their requested time frame. (Attached)

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

Implemented ([redacted] - 03/29/2024)

25b - Contract Signatures

3. 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 #1 was admitted to the home's SDCU on [redacted]. The resident's contract specifies that the resident is part of the connections club program, which is not available to residents in the SDCU. The contract also doesn't specify that the resident is in the SDCU.

Plan of Correction ***Accept ([redacted] - 02/12/2024)***

1- The Executive Director educated both the Sales Department and the Business Office Manager on the regulation

25b Contract Signatures (continued)

2600.25.b (attached).

2 Going forward, the Director of Sales, Business Officer Manager and the Executive Director will sign off on every new resident after reviewing the contract and paperwork to ensure the contract is properly reflecting where the resident will be residing and what services the resident will be receiving. (See attached)

3 The facility audited 60 resident contracts for compliance, and all were in compliance. (Attached). The facility will continue to do audits on the additional contracts to ensure ongoing compliance. Compliance will be the responsibility of the Business Office Manager, Executive Director, Sales Directors or any other assigned Designee.

Licensee's Proposed Overall Completion Date: *02/06/2024*

Implemented (- 03/29/2024)

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #2 was admitted on . On , resident #2 suffered an unwitnessed fall with a to the eyebrow and arm. Resident #2 was sent to the hospital for evaluation. Resident #2 returned to the home with no new orders. Nursing notes indicate that resident #2 was placed on 48 hour Nuero checks. However, there was no documentation that the checks were being done. On , resident #2 began hallucinating. Records stated that resident #2 reported hearing the tv and radio on when they weren't, heard children singing, people talking in the residents' rooms when no one was there and saw vines climbing the walls. On , resident #2 put a Styrofoam container in the microwave that triggered the fire alarm. Resident #2 didn't comprehend fire safety education told to her by responding fire personnel. On , resident #2 continued to hallucinate and attempted to elope. Resident #2 had unwitnessed falls which resulted in hospital visits on Resident #2 passed away on due to after being hospitalized after the last fall on . The home was aware of the residents decline and did not take the appropriate steps to ensure his/her safety or assess them for the correct level of care in a timely fashion.

Plan of Correction ***Accept (- 02/12/2024)***

1 Education and training on Regulation 2600.42b was completed with all staff by the Executive Director and Director of Nursing on 2/6/2024. (Attached)

2 We will conduct bi yearly mandatory abuse training in the building that will be ran by the Ombudsman, Eileen Barlow. Our next one is scheduled for June 4, 2024.

3 The Executive Director, Director of Nursing, Connections Director will continue to educate new employees on what abuse is and how to report abuse to all incoming staff and monitor any complaints immediately when they are received during their first week of employment with Providence Place.

Licensee's Proposed Overall Completion Date: *02/08/2024*

Implemented - 03/29/2024)

82c - Locking Poisonous Materials

5. Requirements

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

Description of Violation

Department Representative noted packages of Lysol Disinfectant wipes in the unlocked upper and lower cabinets of the Activities Room in Connections South Memory Care.

Plan of Correction ***Accept (- 02/05/2024)***

1-Upon discovery of the Lysol Disinfectant wipes in the unlocked upper and lower cabinets of the Activities Room in Connections South, it was corrected immediately at time of inspection by being locked up.
2- Education on regulation 2600.82c was completed with the Connections Director along with all direct care staff on 1/26/2024 and 1/29/2024 (please see attachment).
3- An audit was created (please see attached) to do random chemical checks in two areas biweekly for three weeks and then monthly for two consecutive months for 100% compliance on all memory care common areas. Compliance with regulation 2600.82(c) is the responsibility of the Connections Director, Executive Director or designee.

Licensee's Proposed Overall Completion Date: *05/08/2024*

Implemented (- 03/29/2024)

91 - Telephone Numbers

6. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The telephone numbers required by this regulation were not posted by the phone located in resident room #242.

Plan of Correction ***Accept (- 02/05/2024)***

1- Immediately upon notification during inspection on 1/11/2024, emergency telephone numbers were posted by the telephone in room #242. (Attached)
2- All facility phones were checked to ensure emergency phone numbers were posted
3- The Executive Director, Director of Nursing, Housekeeping Manager, Connections Director and other designees will conduct an audit of 30 residents rooms monthly starting 1/29/2024 until 100% compliant for 3 consecutive months. (Attached)
4- The Executive Director and Director of Nursing will provide education to the staff of the regulatory requirement 2600.91 (attached)

Licensee's Proposed Overall Completion Date: *01/29/2024*

Implemented (- 03/29/2024)

101j7 - Lighting/Operable Lamp

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

101j7 - Lighting/Operable Lamp *(continued)*

Description of Violation

Resident #3 did not have a bedside lamp within reach of their bed.

Plan of Correction ***Accept [redacted] - 02/05/2024)***

1- Upon discovery that resident #3 did not have a lamp or other source of lighting within reach that could be turned on at bedside, the nightstand was immediately moved closer to correct the finding.
2- All staff were trained on this regulation 2600.101j7 that a resident must have a bedside lamp within reach of their bed. (Attached)
3- Beginning 1/27/2024, the CN Director, Executive Director, Director of Nursing or Designee will audit 5 resident rooms on the Connections Neighborhood and 5 resident rooms in Personal care weekly x 4 weeks, then bi-weekly for 2 weeks, then monthly for 1 month to validated sustained compliance with operable lamp at bedside. (See attached)

Licensee's Proposed Overall Completion Date: *04/25/2024*

Implemented [redacted] - 03/29/2024)

103g - Storing Food

8. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

Two packages of dried cereal and a bag of potato chips were found not properly sealed in the cabinet located in the Connections Dining Area.

Plan of Correction ***Accept ([redacted] - 02/05/2024)***

1- Immediately upon notification during inspection, all food was properly sealed and stored in the cabinet located in the Connections Dining Area.
2- Education on regulation 2600.103g was completed with all staff (attached)
3- The Connections Director or Designee will randomly audit the Connections Dining Rooms along with the Activity Rooms on both Terrace and South and the Executive Chef or Designee will randomly audit the Main Dining Room and the Kitchen biweekly for three weeks and then monthly until there are two consecutive months of compliance beginning on 1/29/2024. (attached)

Licensee's Proposed Overall Completion Date: *05/11/2024*

Implemented ([redacted] - 03/29/2024)

103i - Outdated Food

9. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

The refrigerator located in the activities area was found to have a box of Christmas cookies, a small container of Christmas cookies, and 2 small takeout cups of Ranch dressing. In the freezer located in the activities area was a Dutch apple pie. Additionally, also located in the activities area cupboard was a bag of rice crispy cereal that was opened. None of these items were dated when they were opened or placed in the activities area.

103i - Outdated Food (continued)

Located in the main kitchen walk in freezer were 2 bags of vegetables that were not dated.

Plan of Correction ***Accept [redacted] - 02/05/2024)***

1- The following corrective action was completed at time of survey on 1/3/2024- The box of Christmas cookies, small container of Christmas cookies, 2 small takeout cups of Ranch dressing, Dutch apple pie and rice crispy cereal were all thrown out from the Connections activities area. The 2 bags on vegetables that were not dated in the main kitchen walk in freezer on 1/11/2024 were immediately thrown out at the time of the survey walkthrough.
2- All appropriate staff were reeducated on regulation 2600.103i on the correct way to properly label and date food. (See attached).
3- Random audits will be completed by the Executive Chef or Designee in the kitchen and the Connections Director or Designee in the Connections Neighborhood biweekly for three weeks and then monthly until there are two consecutive months of 100% compliance beginning on 1/29/2024. (attached)

Licensee's Proposed Overall Completion Date: *05/11/2024*

Implemented ([redacted] - 03/29/2024)

125a - Combustible Storage

10. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

Department Representative observed the following in each laundry room: a paper with a resident's name on it behind the dryers lying on top of electrics wires and dryer exhaust hose in the 3rd north laundry room and a pair of underwear, a bra, hankie, and a sock behind the dryer in 3rd South.

Plan of Correction ***Accept [redacted] - 02/05/2024)***

1- Upon discovery of paper behind the dryers lying on top of electrical wires and dryer exhaust hose in the 3rd north laundry room and a pair of underwear, a bra, hankie and a sock behind the dryer in 3rd south, the Maintenance Director immediately removed the items on 1/3/2024.
2- Education was completed by the Executive Director and Maintenance Director to all Housekeeping and Direct Care Staff (see attached) on regulation 2600.125a
3- The Maintenance Director, Housekeeping Manager, Executive Director or Designee will check 2 random laundry rooms weekly beginning on 1/29/2024 for four weeks, then biweekly for two weeks and then monthly for two months.

Licensee's Proposed Overall Completion Date: *01/29/2024*

Implemented [redacted] 03/29/2024)

141a 1-10 Medical Evaluation Information

11. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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 was admitted to [redacted] on [redacted]. DME dates have been altered from [redacted]
Resident #4's most recent medical evaluation was completed on [redacted] The DME did not include resident's weight.
Resident #4's previous DME was completed on [redacted]. The DME did not include the resident's weight.
Resident #5's most recent medical evaluation was completed on [redacted] However, the evaluation does not have a medical professional license number.

Plan of Correction ***Accept ([redacted] - 02/05/2024)***

1- Upon DHS finding DME's were corrected and are attached.
2- Education completed with Director of Nursing, Connections Director, Executive Director and Sales Director and Sales Coordinator on Regulation 141a 1-10.
3- Admission checklist to be completed on all new admissions
4- Biweekly audit for 2 weeks and then monthly for 2 months on 5 random DME's to assure compliance beginning week of 1/29/2024 by Connection Director, Director of Nursing or Designee.

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

Implemented ([redacted] - 03/29/2024)

181c - Self-administration Assessment

12. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #6 was found to have a bottle of [redacted] and Resident #2 had tubes of [redacted] that was observed on their bedside tables. Resident #6 and #7 DMEs indicate they are not capable of self-medicating.

Plan of Correction ***Accept ([redacted] - 02/05/2024)***

1- Upon discovering Resident #6 having a bottle of [redacted] and Resident #2 having a tube of [redacted] in their rooms on [redacted], the items were removed immediately from the residents' rooms and locked in the med cart.

181c - Self-administration Assessment (continued)

2- Resident #6 and Resident #2 are unable to pass a self med assessment, therefore all medications will be kept locked in the medication cart.

3- Education was completed with all nursing staff on 1/30/2024 on regulation 2600.181c

4- Beginning 1/29/2024, the Director of Nursing, Executive Director or Designee will audit 10 resident rooms weekly x 4 weeks, then bi-weekly for 2 weeks, then monthly for 2 month to ensure no prescribed meds are stored in the resident's room unless they have a self medication assessment completed. (See attached)

Licensee's Proposed Overall Completion Date: *01/29/2024*

Implemented [redacted] - 03/29/2024)

183b - Meds and Syringes Locked

13. Requirements

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

Description of Violation

On 1/11/24 at 12:30pm, [redacted] was unlocked, unattended, and accessible in resident #6's room and [redacted] Cream was unlocked, unattended, and accessible in resident #7's room.

Plan of Correction ***Accept ([redacted] - 02/05/2024)***

1- Upon discovery on 1/11/2024 of the [redacted] in residents #6 room and the [redacted] in residents #7 room all items were removed from the residents' rooms and locked in the med cart on the day of inspection.

2- Education was completed with all nursing staff on 1/29/2024 on regulation 2600.183b

3- Beginning 1/29/2024, the Director of Nursing, Executive Director or Designee will audit 10 resident rooms weekly x 4 weeks, then bi-weekly for 2 weeks, then monthly for 2 month to ensure no prescribed meds are stored in the resident's room. (See attached)

Licensee's Proposed Overall Completion Date: *05/25/2024*

Implemented ([redacted] - 03/29/2024)

185a - Implement Storage Procedures

14. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #8 is prescribed [redacted] chew twice daily (supplement) and [redacted] units subq once daily. Resident did not receive [redacted] dose on [redacted] due to medication not available in home.

Plan of Correction ***Accept ([redacted] - 02/05/2024)***

1- Accuflo MARs will be updated for MT/LPN each shift to check for any medications to be refilled to ensure medications are on hand to be administered.

2- Director of Nursing provided education to all nursing staff on Regulation 2600.185a beginning on 1/30/2024

185a - Implement Storage Procedures (continued)

3- Director of Nursing or Designee will perform audits of 5 residents' medications weekly for four weeks beginning on 1/31/2024, biweekly for three weeks then monthly for one month to ensure medications are available as ordered.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented [redacted] - 03/29/2024)

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

Resident #8 is prescribed [redacted] chew twice daily (supplement) and [redacted] units subq once daily (DM). Resident did not receive [redacted] dose or [redacted].
Resident #11 is prescribed [redacted] ml tablet once daily with instructions to hold if systolic blood pressure (SBP) is less than 110. On [redacted], the resident's SBP measured [redacted]; however, the MAR indicates the medication was held.
Resident #11 is prescribed [redacted] tab twice daily with the instructions to hold is SBP is less than [redacted]. On [redacted], the resident's SBP measured [redacted]; however, the MAR indicates the medication was held.
Resident #11 is prescribed [redacted]. every 8 hrs. with the instructions to hold is SBP is less than 110. On [redacted], the resident's SBP measured [redacted] however, the MAR indicates the medication was administered.
Resident #12 is prescribed [redacted]. twice daily with instructions to hold for SBP less than [redacted]. On [redacted] at [redacted], the resident's SBP measured [redacted]; however, the MAR indicates the medication was held.
Resident #13 is prescribed [redacted] flex pen with a sliding scale. Review of her glucometer indicates a blood glucose level of [redacted] on [redacted]. 2 units of insulin were required for a level of [redacted]. However, the resident's MAR indicates the medication was withheld due to parameters.

Plan of Correction ***Accept ([redacted] - 02/12/2024)***

1- Director of Nursing provided education beginning 2/1/2024 to the nursing staff on Regulation 2600.187d which included how to properly read sliding scale insulin orders and administer/document accurate dosages according to physician orders. Staff education was also provided on how to distinguish on systolic and diastolic blood pressure and when medications should be administered or held according to physician orders. (Attached)
2- Director of Nursing will be responsible for ensuring compliance of Regulation 2600.187d beginning 2.5.2024

Licensee's Proposed Overall Completion Date: *02/06/2024*

Implemented ([redacted] 03/29/2024)

188b - Medication Error Reporting

17. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

188b Medication Error Reporting *(continued)*

Description of Violation

Resident #8 is prescribed [redacted] chew twice daily (supplement) and [redacted] subq once daily (DM). Resident did not receive [redacted] dose or [redacted] on [redacted]. The medication error was not reported to the department.

Plan of Correction ***Accept ([redacted] - 02/12/2024)***

1 The medication error for Resident #8 was reported to the Department immediately upon discovery of the missed report. (Attached)

2 The Director of Nursing, Connections Director, LPN's and Med Tech's were educated on 1/30/2024 of what constitutes as a medication error and the need to report to the Director of Nursing, Executive, Director of Connections, MD, resident and designated person.

3 The Director of Nursing, Brittany Gaffney, will monitor ongoing compliance of Regulation 2600.188b Medication Error Reporting.

Licensee's Proposed Overall Completion Date: *02/06/2024*

Implemented ([redacted] - 03/29/2024)

190a - Completion Medication Course

18. Requirements

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

Description of Violation

Records for Staff Person B, hired on [redacted], indicate they scored an 86 on their Initial Medication Administration Training Exam completed on [redacted] and have been passing medications since then. A score of 90 or above is required prior to passing medications.

Plan of Correction ***Accept ([redacted] - 02/12/2024)***

1 Staff Person B was immediately removed from the Med Cart upon discovering on [redacted] that [redacted] had received an 86 or [redacted] Initial Medication Administration Training Exam completed on 6/6/2022.

2 Staff Person B worked as an RLA while [redacted] worked on [redacted] MT Course from 1/3/2024 to 1/29/2024

3 Staff Person B successfully completed the PA Department of Human Services MT Training Course with a score of 90% or greater. Staff Person B passed [redacted] test with 97% on 1/12/2024. (Paperwork attached)

4 Staff Person B was observed passing medications by [redacted] on 1/30/2024 and completed successfully.

5 An audit of all current MT's was completed on 2/6/2024 with 100% compliance. (Attached)

5 Director of Nursing or Designee will be responsible for monitoring ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/06/2024*

Implemented ([redacted] - 03/29/2024)

227c - Support Plan Revision

19. Requirements

227c - Support Plan Revision *(continued)*

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

Description of Violation

Resident #4 's assessment and support plan was completed on [redacted]. Resident was admitted to hospice services on [redacted]. The support plan was not updated to indicate the change in care needs of the resident.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

1- We will ensure all assessments and support plans are updated including being admitted to hospice
2- Education was completed with Director of Nursing, Connections Director, and Executive Director on Regulation 2600.227c
3- Random audits on charts will begin on 1/31/2024 on 5 residents' charts and will be biweekly for 3 weeks then monthly for 2 months until 100% compliant. D
4- Director of Nursing, Connections Director, Executive Director or Designee will be responsible for monitoring ongoing compliance of Regulation 2600.227c.

Licensee's Proposed Overall Completion Date: *02/06/2024*

Implemented ([redacted] - 03/29/2024)

227d - Support Plan Medical/Dental

20. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #8's assessment and support plan were completed on [redacted]. Page 1 of the assessment referred to the resident as "resident". Page 3 of the assessment refers to the resident by a different name, not the residents name. Nowhere in the resident's record was it indicated that this is the name the resident preferred.
Resident #2's Assessment and support plan was completed on [redacted]. On [redacted], resident went to the hospital after a fall. Nuero checks are documented in the nursing notes but not documented in the RASP. Resident had falls on [redacted]. None of the falls are documented and no additional supports or safeguards are put in place to ensure the residents safety. Repeat violation from 9/26/23.

Plan of Correction ***Accept ([redacted] - 02/12/2024)***

1- The Director of Nursing and the LPN Supervisors immediately fixed the face sheets to ensure residents that have a preferred name were reflective of that on the new face sheets. Face sheets were immediately updated in the resident charts beginning on 1/4/2024.
2- Education was completed with nursing staff on Regulation on 2600.227d on 1/31/2024.
3- Random audits will be conducted periodically by the Director of Nursing or other Designee to ensure compliance of Regulation 2600.227d.

Licensee's Proposed Overall Completion Date: *02/06/2024*

227d - Support Plan Medical/Dental *(continued)*

Implemented (- 03/29/2024)

231c - Preadmission Screening

21. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #9 was admitted to the home on . On , Resident was admitted to SDCU. The prescreen was completed on this date. However, the cognitive screen was not signed.

Plan of Correction ***Accept - 02/12/2024)***

1-Director of Nursing, Connections Director, Sales Director, Sales Coordinator and Executive Director were all educated on Regulation 2600.231c on 1/31/2024. (Attached).
2- Moving forward we will ensure all cognitive screens are signed prior to resident being moved to the secured connections neighborhood
3- The facility completed an audit on 2/7/2024 of 22 resident's preadmission screenings and all were in compliance. (Attached). The facility will continue to do audits on the additional preadmission screenings to ensure ongoing compliance. Compliance will be the responsibility of the Connections Director, Executive Director, Sales Directors or any other assigned Designee.

Licensee's Proposed Overall Completion Date: *02/07/2024*

Implemented - 03/29/2024)

252 - Record Content

22. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
10. A record of incident reports for the individual resident.

Description of Violation

On 11/7/23, Resident #2 put an empty Styrofoam container in the microwave resulting in the fire alarm going off. Security system dispatched fire trucks to the community. They assessed the situation and found no danger. A copy of the incident report is required to be placed in the residents' records. However, it was not in the resident record. Staff Member A indicated that a copy of incident reports are not put into resident records only into the state reportable binder.

Plan of Correction ***Accept (- 02/12/2024)***

1- Education was completed with Executive Director, Director of Nursing and Connections Director on regulation 2600.252 (attached)
2- An audit will be done monthly for the previous month starting 2/1/2024 (attached) by the Executive Director and Director of Nursing in Personal Care and the Executive Director and the Connections Director in Connections.
3- The audits will be completed monthly by the Executive Director, Connections Director, Director of Nursing or Designee until audits are in 100% compliance for 3 full consecutive months.

Licensee's Proposed Overall Completion Date: *02/06/2024*

252 - Record Content *(continued)*

Implemented ([redacted] - 03/29/2024)