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

April 16, 2024

[redacted], ADMINISTRATOR
INSPIRIT MACUNGIE OPERATOR LLC
6488 ALBURTIS ROAD
MACUNGIE, PA, 18062

RE: THE WILLOW, AN INSPIRIT SENIOR LIVING COMMUNITY
6488 ALBURTIS ROAD
MACUNGIE, PA, 18062
LICENSE/COC#: 22681

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/03/2024 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: *THE WILLOW, AN INSPIRIT SENIOR LIVING COMMUNITY* **License #**: *22681* **License Expiration**: *11/07/2024*

Address: *6488 ALBURTIS ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *INSPIRIT MACUNGIE OPERATOR LLC*

Address: *6488 ALBURTIS ROAD, MACUNGIE, PA, 18062*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *01/20/2007* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *40* **Waking Staff**: *30*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *01/03/2024*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* **Residents Served**: *35*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *35*

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

Have Mobility Need: *5* **Have Physical Disability**: *1*

Inspections / Reviews

01/03/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/20/2024*

01/29/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/09/2024*

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

Inspections / Reviews *(continued)*

02/02/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/09/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/09/2024*

04/16/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/09/2024*

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

18 - Compliance With Laws

1. Requirements

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

Description of Violation

The home's battery operated Carbon Monoxide detector located above the rear kitchen door documented a date that the batteries were last changed on 10/31/22.
Repeat violation 11/30/23.

Plan of Correction ***Accept [redacted] - 01/26/2024)***

The battery was changed at the time of inspection. The Maintenance Director was educated on 1.3.24 about changing the battery every six (6) months. The Maintenance Director or designee will be responsible for changing the battery on all carbon monoxide detectors every six (6) months in January and July. A preventive maintenance task has been added to the maintenance tracking system to complete in January and July. An Outlook calendar invite was created as a reminder to change the batteries every six (6) months. The Executive Director or designee will monitor that the batteries have been changed.

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

Implemented [redacted] - 04/16/2024)

65f - Training Topics

2. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
6. Safe management techniques.

Description of Violation

Staff persons A and B did not have training in Medication Self Administration and Safe Management Techniques for the 2023 training year.

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

Staff persons A and B will complete training topics medication self-administration and safe management techniques by 2.9.24.
All staff training records for 2023 will be reviewed by the Executive Director by 2.9.24 to ensure that all staff have completed the required training topics for 2023. Results of the audit will be reviewed at the monthly Quality Assurance Meeting.
The 2024 Staff Training Schedule has been posted on the bulletin board by the time clock. Each staff person is responsible for signing the attendance record for each annual training topic. The Business Office Manager or designee will maintain staff training records. The Resident Wellness Director or designee is responsible for ensuring that all DCS complete annual training topics. The Executive Director or designee will review completed staff training at the monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *02/09/2024*

Implemented [redacted] - 04/16/2024)

65g Annual Training Content

3. 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:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
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

Staff person B did not have training in the following required annual training topics for the 2023 training year: Fire safety by a fire safety expert, resident rights, Older Adult Protective Services Act, and falls and accident prevention.

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

Staff person B will complete training topics fire safety by the ED who is a staff person trained by a fire safety expert; Resident Rights; The Older Adult Protective Services Act (35 P.S. §§ 10225 101 – 10225.51-2); and Falls and Accident Prevention by 2.9.24.
All staff training records for 2023 will be reviewed by the Executive Director or designee by 2.9.24 to ensure that all staff completed required training topics for 2023. Results of the audit will be reviewed at the monthly Quality Assurance Meeting.
The 2024 Staff Training Schedule has been posted on the bulletin board by the time clock. Each staff person is responsible for signing the attendance record for each annual training topic. The Business Office Manager or designee will maintain staff training records. The Resident Wellness Director or designee is responsible for ensuring that all DCS complete annual training topics. The Executive Director or designee will review completed staff training at the monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *02/09/2024*

Implemented (- 04/16/2024)

81b Resident Personal Equipment

4. Requirements

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

Description of Violation

Resident #1 uses an enabler bar for stability. The device is U shaped. The device was uncovered with an opening that measured approximately 11 inches wide.

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

The enabler bar for Resident 1 was covered on the day of inspection and added to the resident's RASP.
On 1.8.24 the Resident Wellness Director (RWD) completed an audit of all resident apartments. Five residents were identified as needing enabler bars. The RWD will contact the responsible party for resident's who need an enabler bar to obtain an FDA approved enabler bar by 2.9.24. Resident RASPs will be updated to reflect:
o The specific need for the device

81b - Resident Personal Equipment (continued)

o The intended use and any risks associated with the use of the device
o The resident's ability to use the device safely for the purpose it was intended
o Identification of the specific device to be used and whether a cover is required to meet FDA guidelines
Staff will be educated by the RWD or designee on or before 1.31.24 on the FDA and DHS guidelines for use of bedside mobility devices.
The Resident Wellness Director or designee is responsible for ensuring that any resident who requires an enabler bar is assessed for the need, ability to use the device, that the device meets the FDA requirements; and the use of the enabler bar is documented on the resident's RASP. Beginning in February the RWD or designee will complete a monthly audit for 3 months to ensure compliance. The results of the audit will be reviewed by the ED at the monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *02/09/2024*

Implemented (- 04/16/2024)

89b - Hot Water Temperature

5. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

The water temperature measured 122.5 degrees in the bathroom sink of Resident room # 316.
Repeat violation 11/30/22.

Plan of Correction ***Accept (- 01/29/2024)***

Wertz Plumbing adjusted the settings on the hot water heater tanks on 1.12.24. The hot water temp is set at 114 degrees.
The Maintenance Director will be re-educated on or before 1.31.24 about hot water temperatures not exceeding 120 degrees. The Maintenance Director or designee is responsible for monitoring hot water temperatures as part of the preventative maintenance program. Beginning the week of 1.22.24 the Executive Director or designee will complete random audits of the hot water temperatures in resident apartments three (3) times a week for three (3) weeks; two (2) times a week for two (2) weeks; and one (1) time a week for one (1) week. The results will be reviewed by the ED at the monthly Quality Assurance meeting.

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

Implemented - 04/16/2024)

96a - First Aid Kit

6. 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 located in the 1st floor stairwell did not contain antiseptic.

96a First Aid Kit *(continued)*

Plan of Correction ***Accept (- 01/29/2024)***

Antiseptic was placed in the first aid kit located in the 1st floor stairwell.
All staff will be re educated by the RWD or designee on or before 1.31.24 on the required contents of first aid kits and the process to replace contents after each use, including dating and initialing the zip tie to verify all required contents are present. Beginning the week of 2.5.24 the RWD or designee will audit all first aid kits for required contents weekly for one month. The results of the weekly audits will be reviewed by the ED at the monthly Quality Assurance meeting. Thereafter, the RWD or designee will be responsible for auditing all first aid kits monthly and documenting on the monthly First Aid Content form inside each first aid kit.

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

Implemented - 04/16/2024)

105g - Lint Removal and Duct Cleaning

7. Requirements

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

Description of Violation

The dryer located in the 2nd floor laundry room had a broken lint filter and a collection of lint behind the filter.

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

The maintenance director ordered a new lint filter for the dryer on the 2nd floor laundry which will be replaced on or before 2.9.24.
Staff will be re educated on or before 1.31.24 about cleaning the dryer lint filter after each load and to let the Maintenance Director know if there are any problems.
The Maintenance Director or designee is responsible for ensuring that lint filters are in good repair and order replacements for damaged lint filters. The Maintenance Director completed an audit of all dryers on 1.14.24. Beginning 1.22.24 the Executive Director or designee will complete random audits of dryer lint three (3) times a week for three (3) weeks; two (2) times a week for two (2) weeks; and one (1) time a week for 1 week to ensure ongoing compliance with lint removal. The results will be reviewed by the ED at the monthly Quality Assurance meeting.

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

Implemented (- 04/16/2024)

132b - Safety Inspection/Fire Drill

8. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home had required fire safety inspections conducted by a fire safety expert on 2/3/22 and then again on 4/28/23, more than 12 months apart.

132b - Safety Inspection/Fire Drill *(continued)*

Plan of Correction ***Accept [redacted] - 01/29/2024)***

On 1.10.24 the Executive Director contacted Robert Muller, Fire & Life Safety Solutions, LLC to complete the annual fire safety inspection and observed fire drill prior to April 2024. The Maintenance Director is responsible for scheduling and ensuring the annual fire safety inspection and observed fire drill is completed annually by a fire safety expert. The Executive Director or designee will review the monthly fire drills at the monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *04/26/2024*

Implemented ([redacted] - 04/16/2024)

132c - Fire Drill Records

9. Requirements

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

Description of Violation

Fire drills conducted and recorded on the home's fire drill logs had only the minutes documented for the evacuation times for the following dates: 9/21/23, 10/25/23, 11/21/23, and 12/27/23.

Plan of Correction ***Accept [redacted] - 01/29/2024)***

On 1.10.24 the Executive Director contacted [redacted], Fire & Life Safety Solutions, LLC to conduct monthly Fire Drills for The Willow including documentation of the minutes and seconds of fire drill evacuation. The Maintenance Director will be re-educated on or before 1.31.24 on the requirements of 2600.132c documenting the minutes and seconds of evacuation for fire drills. The Executive Director will review the monthly documentation of Fire Drill records at the monthly Quality Assurance meeting.

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

Implemented ([redacted] - 04/16/2024)

141a 1-10 Medical Evaluation Information

10. 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

The Documentation of Medical Evaluation (DME) form completed [redacted] for resident #2 did not include blood pressure, pulse rate, temperature, height, or weight.
Repeat violation 11/30/22

Plan of Correction ***Accept [redacted] - 01/29/2024)***

On 1.2.24, prior to the onsite DHS inspection, the new RWD completed a self-audit on all resident records for compliance on Prescreens, DMEs, RASPs. All resident records identified as being out of compliance with prior annual dates for Prescreens, DMEs and RASPs are unable to be corrected and notation was added to the record indicating that "Per POC for LIS 1.3.24 this record was audited on 1.2.24 and noted to be out of compliance with annual due date for DME or RASP; and reviewed at the January 2024 Quality Assurance Meeting. Going forward the annual DME/RASP will be completed within the required timeframe." The new Executive Director created an Excel spreadsheet to track due dates for resident DMEs and RASPs. The RWD or designee is responsible for ensuring that the resident DME and RASP is completed within the required timeframe, including the content of 141a 1-10. The RWD and ED will review all new and annual DMEs to ensure compliance.

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

Implemented [redacted] - 04/16/2024)

141b1 - Annual Medical Evaluation

11. Requirements

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

Description of Violation

Resident #3 had documented medical evaluations completed on [redacted] and then again on [redacted], more than 12 months later.

Plan of Correction ***Accept [redacted] - 01/29/2024)***

On 1.2.24, prior to the onsite DHS inspection, the new RWD completed a self-audit on all resident records for compliance on Prescreens, DMEs, RASPs. All resident records identified as being out of compliance with prior annual dates for Prescreens, DMEs and RASPs are unable to be corrected and notation was added to the record indicating that "Per POC for LIS 1.3.24 this record was audited on 1.2.24 and noted to be out of compliance with annual due date for DME or RASP; and reviewed at the January 2024 Quality Assurance Meeting. Going forward the annual DME/RASP will be completed within the required timeframe." The new Executive Director created an Excel spreadsheet to track due dates for resident DMEs and RASPs. The RWD or designee is responsible for ensuring that the resident DME and RASP is completed within the required timeframe, including the content of 141a 1-10. The RWD and ED will review all new and annual DMEs to ensure compliance.

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

Implemented [redacted] - 04/16/2024)

182b - Prescription Medication

12. Requirements

2600.

182b Prescription Medication *(continued)*

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

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On [redacted] there was no med tech or other licensed staff scheduled and available to administer medications if needed.

Plan of Correction ***Accept ([redacted] - 01/29/2024)***

On 12.23.23 from 3pm to 7pm the community did have a qualified Med Tech on duty. (see timecard). The RCC had not updated the staff schedule. The RWD re educated the RCC on 1.15.24 that all DCS changes must be updated on the staff schedule to reflect adequate coverage. The RWD or designee is responsible for ensuring that the staff schedule accurately reflects DCS and Med Tech coverage. Beginning the week of 2.5.24 the RWD will review the staff schedule weekly for four (4) weeks to audit that changes have been updated on the staff schedule. The results of the weekly audit will be reviewed by the Executive Director at the monthly Quality Assurance meeting.

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

Implemented ([redacted] - 04/16/2024)

183e - Storing Medications

13. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

The [redacted] for resident #4 was not dated when the pen was opened for use. The [redacted] for resident #5 was not dated when the pen was opened for use. According to manufacturer's instructions, the pens are to be discarded 28 days after they are opened for use.

Also, the [redacted] belonging to resident #2 was not dated when the cannister was inserted for use. According to manufacturer's instructions, the cannister should be discarded 3 months after insertion for use.

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

The undated insulin pens for residents #4 and #5 were discarded and a new insulin pen was obtained and dated for each resident. A new [redacted] was obtained and dated for resident#2.

The RWD will hold an in service on or before 2.9.24 to re educate all Med Techs on dating medications when opened; expiration dates for insulin, inhalers and other medications; reordering medication procedures and how to complete a MAR to medication cart audit using an audit tool to ensure that all medications are available.

Beginning the week of 2.5.24 the RWD or designee will complete weekly medication cart audits for four (4) weeks to ensure compliance. The results of the weekly medication cart audits will be reviewed by the Executive Director at

183e - Storing Medications (continued)

the monthly Quality Assurance meeting.

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

Implemented [redacted] - 04/16/2024)

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

The home did not have the following PRN medications available for administration for the following residents:
Resident #6, [redacted]
Resident #4, [redacted] glucose tablets

Plan of Correction ***Accept ([redacted] - 01/29/2024)***

The PRN [redacted] for Resident #6; and the [redacted], and glucose tablets for Resident #4 were reordered on the day of DHS inspection.
The RWD will hold an in-service on or before 1.31.24 to re-educate all Med Techs on dating medications when opened; expiration dates for insulin, inhalers and other medications; reordering medication procedures and how to complete a MAR to medication cart audit using an audit tool to ensure that all medications are available.
Beginning the week of 2.5.24 the RWD or designee will complete weekly medication cart audits for four (4) weeks to ensure compliance. The results of the weekly medication cart audits will be reviewed by the Executive Director at the monthly Quality Assurance meeting.

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

Implemented [redacted] - 04/16/2024)

187a - Medication Record

15. Requirements

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

Description of Violation

Residents #4 and #6 both require insulin to be administered on a sliding scale 3 times daily with meals. The home did not record the number of sliding scale insulin units administered on the Medication Administration Records (MARs) for either resident for the month of December 2023.

Plan of Correction ***Accept ([redacted] - 01/29/2024)***

The eMAR was missing the check box for medication technician to document the blood sugar for Resident #4 and #6.
The RWD added the check box for blood sugar documentation on the eMAR
The RWD will hold an in-service on or before 1.31.24 to re-educate all Med Techs on documenting the blood sugar

187a - Medication Record (continued)

reading at the time of the Accu-Chek.
The RCC/RWD or designee is responsible for approving orders on the eMAR entered by the contracted pharmacy, including additional documentation for blood sugars. Beginning 2.1.24, the 3rd shift Med Tech will be responsible to complete a nightly review of glucometer reading to MAR BS documentation using the "Blood Sugar/MAR Audit" form. Beginning the week of 2.5.24 the RWD or designee will complete glucometer to MAR documentation three (3) times a week for three (3) weeks; two (2) times a week for two (2) weeks; and weekly for one (1) week to ensure compliance with blood sugar documentation. The results of the audits will be reviewed by the Executive Director at the monthly Quality Assurance Meetings.

Licensee's Proposed Overall Completion Date: *03/15/2024*

Implemented [redacted] - 04/16/2024)

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

Resident #6 requires insulin to be administered 3 times daily with meals according to a sliding scale. On the following dates readings were documented for 8am (breakfast) administration but were not found in the resident's glucometer: [redacted]

Resident #4 requires insulin to be administered 3 times daily with meals according to a sliding scale. On the following dates readings were documented that were not found in the resident's glucometer: [redacted].

Also, resident #4 requires [redacted] units of [redacted] insulin 3 times daily with meals, to be held if the blood sugar is less than [redacted]. On [redacted] at [redacted] the resident's blood sugar was [redacted] and the insulin was administered. Resident #4 has another order for [redacted] units of [redacted] insulin at bedtime; on [redacted] the insulin was marked not administered on the resident's MAR with no indication as to why the medication was not administered.

Plan of Correction ***Accept [redacted] - 01/29/2024)***

The RWD will hold an in-service on or before 1.31.24 to re-educate all Med Techs on use of resident glucometers and documenting the blood sugar reading at the time of the accucheck. Beginning 2.1.24, the 3rd shift Med Tech will be responsible to complete a nightly review of glucometer reading to MAR BS documentation using the "Blood Sugar/MAR Audit" form. Beginning 2.1.24 the RCC/RWD or designee will review the audit form daily for one (1) month. The results of the audit will be reviewed by the ED or designee at the monthly Quality Assurance meeting.

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

Implemented [redacted] - 04/16/2024)

190b - Insulin Injections

17. Requirements

2600.

190b Insulin Injections *(continued)*

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

Description of Violation

Staff person C is a med tech who passes medications. The home did not have documentation that staff person C has received training from a certified Diabetes instructor within the past 12 months. On [redacted] at [redacted] staff person C initialed resident #4's MAR indicating that they administered [redacted] insulin.

Plan of Correction ***Accept [redacted] - 01/29/2024)***

Staff person C will not administer medications until completion of an approved diabetic training by a Certified Diabetic Educator.
The RWD will hold an in service on or before 1.31.24 to re educate all Med Techs that only Med Techs with current diabetic training may administer accu checks and insulin.
The RWD audited all Med Tech records for current diabetic training. The RWD who is a Certified Medication Train the Trainer is responsible for ensuring that only Med Techs who have current diabetic training administer accu checks and insulin. A tracking tool will be used to track dates for annual diabetic training.

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

Implemented ([redacted] - 04/16/2024)

225a - Assessment 15 Days

18. 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 #1 was admitted to the home on [redacted]. The resident's Resident Assessment and Support Plan (RASP) was not completed until [redacted] The home did not complete an initial assessment of the resident's needs within 15 days of admission.

Plan of Correction ***Accept [redacted] - 01/29/2024)***

On 1.2.24, prior to the onsite DHS inspection, the new RWD completed a self audit on all resident records for compliance on Prescreens, DMEs, RASPs. All resident records identified as being out of compliance with prior initial/annual dates for Prescreens, DMEs and RASPs are unable to be corrected and notation was added to the record indicating that "Per POC for LIS 1.3.24 this record was audited on 1.2.24 and noted to be out of compliance with initial/annual due date for DME or RASP; and reviewed at the January 2024 Quality Assurance Meeting. Going forward the annual DME/RASP will be completed within the required timeframe." The new Executive Director created an Excel spreadsheet to track due dates for resident DMEs and RASPs. The RWD or designee is responsible for ensuring that the resident DME and RASP is completed within the required timeframe, including the content of 141a 1 10. The RWD and ED will review all new and annual DMEs to ensure compliance.

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

Implemented [redacted] - 04/16/2024)

225c - Additional Assessment

19. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #2's support plan for 2022 was completed on [redacted]; the resident's annual support plan for 2023 was completed [redacted], more than 12 months later.

Plan of Correction ***Accept [redacted] - 01/29/2024)***

On 1.2.24, prior to the onsite DHS inspection, the new RWD completed a self-audit on all resident records for compliance on Prescreens, DMEs, RASPs. All resident records identified as being out of compliance with prior annual dates for Prescreens, DMEs and RASPs are unable to be corrected and notation was added to the record indicating that "Per POC for LIS 1.3.24 this record was audited on 1.2.24 and noted to be out of compliance with annual due date for DME or RASP; and reviewed at the January 2024 Quality Assurance Meeting. Going forward the annual DME/RASP will be completed within the required timeframe." The new Executive Director created an Excel spreadsheet to track due dates for resident DMEs and RASPs. The RWD or designee is responsible for ensuring that the resident DME and RASP is completed within the required timeframe, including the content of 141a 1-10. The RWD and ED will review all new and annual DMEs to ensure compliance.

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

Implemented [redacted] - 04/16/2024)

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 #1's support plan dated [redacted] was not updated to reflect that the resident uses an enabler bar for stable transfers from bed.
Resident #7's support plan dated [redacted] was not updated to reflect that the resident uses an enabler bar for stable transfers from bed and also that resident #7 began receiving hospice services on [redacted]

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

Resident #1's RASP was updated to include the use of the bed enabler.
A new RASP had been completed for Resident #7 on [redacted] when [redacted] began receiving hospice services; the use of the bed enabler was added to the RASP.
On 1.8.24 the Resident Wellness Director (RWD) completed an audit of all resident apartments. Five residents were identified as needing enabler bars. The RWD will contact the responsible party for resident's who need an enabler bar to obtain an FDA approved enabler bar by 2.9.24. Resident RASPs will be updated to reflect:

227d - Support Plan Medical/Dental (continued)

o The specific need for the device
o The intended use and any risks associated with the use of the device
o The resident's ability to use the device safely for the purpose it was intended
o Identification of the specific device to be used and whether a cover is required to meet FDA guidelines
DCS will be in-serviced by the RWD on or before 1.31.24 on the FDA and DHS guidelines for use of bedside mobility devices.
The Resident Wellness Director is responsible for ensuring that any resident who requires an enabler bar is assessed for the need, ability to use the device, that the device meets the FDA requirements; and the use of the enabler bar is documented on the resident's RASP. The RWD will complete a monthly audit beginning in February for 3 months to ensure compliance. The results of the audit will be reviewed by the Executive Director at the monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *02/09/2024*

Implemented ([redacted] - 04/16/2024)