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

April 23, 2024

[REDACTED], ASSISTANT OPERATIONS COUNSEL
FDG CB OPCO LLC
[REDACTED]

RE: ATRIA AT CRANBERRY WOODS
3020 FAIRPORT LANE
CRANBERRY TOWNSHIP, PA, 16066
LICENSE/COC#: 45268

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/10/2024, 01/10/2024, 01/17/2024, 01/29/2024 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ATRIA AT CRANBERRY WOODS* **License #**: *45268* **License Expiration**: *04/13/2024*

Address: *3020 FAIRPORT LANE, CRANBERRY TOWNSHIP, PA 16066*

County: *BUTLER* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *FDG CB OPCO LLC*

Address:

Certificate(s) of Occupancy

Type: *I 2* **Date**: *01/29/2021* **Issued By**: *Cranberry Twp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *107* **Waking Staff**: *80*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *01/22/2024*

Inspection Dates and Department Representative

01/10/2024 On Site:
01/10/2024 Off Site:
01/17/2024 Off Site:
01/29/2024 Off Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *78*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *41* **Residents Served**: *25*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *78*
Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *29* **Have Physical Disability**: *1*

Inspections / Reviews

01/10/2024 - Full

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *02/16/2024*

02/21/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/12/2024*
Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *02/28/2024*

02/21/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/12/2024*
Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/15/2024*

04/23/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/12/2024*
Reviewer: [redacted] **Follow Up Type:** *Not Required*

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 has had falls on multiple dates to include [redacted], However Resident #1's most recently completed assessment dated [redacted], indicates a personal care need of resident's fall risk as does not require.

Plan of Correction ***Accept (- 02/20/2024)***

** Resident Service Director completed an assessment and a new service plan/support plan for Resident #1 on [redacted] include fall risk.*
** Resident Service Director/designee will complete an audit of the current residents' service plan/support plan by 3/15/24, to ensure the service plan/support plan document/address the residents fall risk accurately. Any issues found during the audit will be addressed immediately.*
** Regional Care Director will provide additional training to the Executive Director and Resident Services Director/designee by 3/1/24 to ensure service plan/support plans document/address residents fall risk.*
** Executive Director will meet with Resident Services Director/designee weekly starting 2/26/24 for the next 90 days to review all new support plans to ensure service plans/support plans have documentation or address residents fall risk.*

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

Implemented - 04/23/2024)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff member A moved to the Commonwealth of Pennsylvania in [redacted], however, the home did not complete the Federal Bureau of Investigations criminal history check.

Plan of Correction ***Accept - 02/21/2024)***

** The Community Business Director obtained a Federal Bureau of Investigation background check completed for staff member A and filed the results in the staff member's personnel file as of 1/18/24.*
** An Audit was completed by the Community Business Office Director on 1/10/24 to ensure that all staff members that have moved to the Commonwealth of Pennsylvania have a completed Federal Bureau of Investigation criminal history check.*
** Beginning 1/10/24 and continuing for the next 90 days, the Executive Director will review the background checks for all staff members who moved to the Commonwealth of Pennsylvania to ensure compliance.*

Licensee's Proposed Overall Completion Date: *02/17/2024*

Implemented - 04/23/2024)

81b - Resident Personal Equipment

3. 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

At 5:25 p.m., resident #1 had a bedside enabler on the left side of ███ bed. The enabler was able to be moved approximately 4 inches towards the foot of the bed and 4 inches towards the head of the bed, producing a total travel distance of approximately 8 inches.

At 5:25 p.m., resident #1 had a bedside enabler on the left side of ███ bed. The enabler's design possessed within it an open space approximately 4.5 x 12 inches in size, presenting an impingement hazard.

On 8/29/23, resident #1 was found entrapped between the bed's mattress and the adjacent room wall. On 1/10/24, at approximately 5:30 p.m., resident #1's bed remained adjacent to the same room wall. The bed's mattress required little effort to move approximately 1 foot from the wall, creating an entrapment hazard.

At 11:15 a.m., resident #2 had a bedside enabler on the right side of ███ bed. However, the enabler was able to be moved 4 inches towards the foot of the bed and four inches towards the head of the bed, producing a total travel distance of approximately 8 inches.

At 11:15 a.m., there was a bedside enabler on the right side of resident #2's bed. However, the bedside enabler's design possessed within it an open space measuring approximately 4.5 x 14 inches, presenting an impingement hazard.

Plan of Correction ***Accept (███ - 02/21/2024)***

** The Maintenance Director secured the bed enabler for Resident #1 on 1/11/24. Covers were placed on Resident #1 and Resident #2 bed enablers on 1/11/24. The Maintenance Director placed velcro on Resident #1 box spring and mattress on 1/11/24 to prevent entrapment hazard between mattress and wall.*
** The Executive Director/Resident Service Director will work with Resident #1 and Resident #2 and their responsible parties to remove the bedside mobility device and replace with compliant device by 3/15/24.*
** Executive Director/Resident Services Director will audit all bedside mobility devices for compliance with bed rail regulations by 3/4/24 and will work with residents and respective responsible parties to replace, if not meeting the requirements. Resident Services Director/designee will maintain a list of all residents with bedside mobility devices and update the list for newly added devices in state binder.*
** Regional Care Director will train Executive Director and Residents Services Director on specific requirements for these devices by 3/1/24. Residents Services Director/designee will provide training to direct care staff on these requirements by 3/15/24 and to report immediately any non compliant devices to their supervisors to address.*
** Executive Director will send a communication to residents and families regarding compliant bedside mobility checks and advising the community if they are installing a bedside mobility device.*
** Executive Director will do spot checks of the bedside mobility devices, using the list created by the Resident Services Director, weekly starting 3/4/24 for the next 90 days to ensure compliance.*

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

Implemented (███ - 04/23/2024)

85c - Trash

4. Requirements

85c Trash *(continued)*

2600.
85.c. Trash shall be removed from the premises at least once a week.

Description of Violation

At 10:35 a.m., there was an uncovered unattended gray garbage can half-full of refuse, approximately 18 inches from the serving line in the second-floor kitchen.

Plan of Correction ***Accept - 02/21/2024)***

** The Regional Director of Culinary Services immediately replaced the lid to the trash can during the inspection on 1/10/24.*
** The Director of Culinary Services was educated by the Executive Director on the requirement of having covered trash receptacles on 1/11/24.*
** The Director of Culinary Services started random weekly checks on 1/11/24 and continuing for the next 90 days to ensure trash receptacles have lids on them.*

Licensee's Proposed Overall Completion Date: *02/17/2024*

Implemented - 04/23/2024)

85e Trash Outside Home

5. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 11:45 a.m., the home's dumpster located on the left side of the home's property was 1/3 full of refuse. However, the lid located on the right side of the dumpster was opened producing a space of approximately 4 x 6 feet in size.

Plan of Correction ***Accept - 02/21/2024)***

** The Maintenance Director immediately closed the outside dumpster lid during the inspection on 1/10/24. The Maintenance Director placed a sign on the dumpster on 1/11/24 stating the lid must be closed after each use.*
** Beginning 1/11/24 and continuing for the next 90 days, the Maintenance Director/designee will check the dumpster to ensure the lid is closed and review findings with the Executive Director/designee.*

Licensee's Proposed Overall Completion Date: *02/17/2024*

Implemented (- 04/23/2024)

103d Storing Food Off Floor

6. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

At 10:40 a.m., there were 8, 3-gallon ice-cream containers stored on the floor of home's second kitchen's walk-in freezer.

Plan of Correction ***Accept (- 02/21/2024)***

** The Director of Culinary Services immediately removed the container of ice cream from the floor during the inspection on 1/10/24.*
** The Director of Culinary Services in-services all culinary employees regarding proper storing of all food by 1/26/24.*

103d - Storing Food Off Floor (continued)

** Beginning 1/15/24 and continuing for the next 90 days, the Director of Culinary Services will randomly audit of all food storage areas weekly to ensure compliance and review the results with the Executive Director and/or designee.*

Licensee's Proposed Overall Completion Date: *02/17/2024*

Implemented (- 04/23/2024)

103g - Storing Food

7. Requirements

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

Description of Violation

At 10:45 a.m., there was half-full, undated plastic container of diced pineapple in the second-floor kitchen's walk in Kohler.

Plan of Correction ***Accept - 02/21/2024)***

** The Director of Culinary services immediately removed the undated container and disposed of contents during the inspection on 1/10/24.*
** The Director of Culinary Services conducted an audit on all other closed or sealed containers to ensure all were dated on 1/10/24.*
** The Culinary staff was educated by the Director of Culinary Services by 1/19/24 on properly labeling and dating of all food stored in closed or sealed containers.*
** Beginning 1/15/24 and continuing weekly for 90 days, the Director of Culinary Services and/or designee will conduct weekly random audit of proper labeling and dating of all food and review the results with Executive Director/designee.*

Licensee's Proposed Overall Completion Date: *02/17/2024*

Implemented 04/23/2024)

105g - Lint Removal and Duct Cleaning

8. 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

At 10:30 a.m., there was approximately .25 inches of lint in the lint trap of the dryer located in the Life Guidance unit's laundry room.

At 11:22 a.m., there was approximately .5 inches of lint in the lint trap of the dryer located in the second-floor personal care unit's laundry room.

At 11:34 a.m., there was approximately .5 inches of lint in the lint trap of the dryer located in the first-floor personal care unit's laundry room.

Plan of Correction ***Accept - 02/21/2024)***

** The Maintenance Director checked all dryer lint traps and removed all lint on 1/10/24.*

105g - Lint Removal and Duct Cleaning (continued)

** The Maintenance Director updated all housekeeping checklists to reflect daily checks of lint traps on 1/15/24.*
** The Maintenance Director/Assistant Executive Director reeducated the care and housekeeping staff by 1/26/24 regarding cleaning lint traps after each use.*
** The Maintenance Director and/or designee will check lint traps weekly beginning 1/15/24 and continuing for the next 90 days to ensure compliance.*

Licensee's Proposed Overall Completion Date: *02/17/2024*

Implemented (- 04/23/2024)

132e - Fire Drill Sleeping Hours

9. Requirements

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

Description of Violation

The most recent fire drill held during sleeping hours was conducted on 9/14/23, at 4:15 a.m. However, the fire drill conducted during sleeping hours prior to 9/14/23, was held on 2/5/23, at 2:36 a.m.

Plan of Correction ***Accept (- 02/21/2024)***

** The Executive Director reeducated the Maintenance Director on 1/12/24 on the requirement on conducting a fire drill at least once every 6 months during sleeping hours.*
** The Executive Director established future drill dates and times on 2/6/24 to include nighttime hours and placed them on calendar as a reminder.*
** The Quality/Risk Management committee led by the Executive Director on 2/21/24 added an item to agenda each month to review frequency and implementation of fire drills to ensure sleeping hour drills are conducted.*

Licensee's Proposed Overall Completion Date: *02/22/2024*

Implemented (- 04/23/2024)

132f - Alternate Exit Routes

10. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The home's evacuation exits are stairwells 4, 5, and 6. However, the home failed to use alternating evacuation exits during fire drills completed from 1/26/23, to 11/18/23; 1/26/23, at 1:25 p.m., exit used stairwells 4,5, and 6, 2/5/23, at 2:36 a.m., exit used stairwells 4, 5, and 6, 3/30/23, at 3:09 p.m., exit used stairwells 4, 5, and 6, 4/9/23, at 4:05 p.m., exit used stairwells 5, and 6, 5/24/23, at 9:30 a.m., exit used stairwells 4, 5, and 6, 6/20/23, at 2:05 p.m., exit used stairwells 4, 5, and 6, 7/10/23, at 7:40 p.m., exit used stairwells 4, 5, and 6, 8/25/23, at 11:01 a.m., exit used stairwells 4, 5, and 6, 9/14/23, at 4:15 a.m., exit used stairwells 4, 5, and 6, 10/5/23, at 2:27 p.m., exit used stairwells 4, 5, and 6, 11/18/23, at 3:40 p.m., exit used stairwells 4, 5, and 6.

Plan of Correction ***Accept - 02/21/2024)***

** Technical assistance was provided by the surveyor on 1/10/24 on how to complete fire drill documentation with the Maintenance Director.*
** The Maintenance Director has designated each fire safety area with a number/letter (4A,4B,4C/5A,5B,5C/6A,6B,6C) on 1/26/24.*

132f - Alternate Exit Routes (continued)

** Beginning 2/1/24 and continuing for the next 90 days, The Executive Director/designee will review Fire Drill documentation to ensure compliance.*

Licensee's Proposed Overall Completion Date: *02/17/2024*

Implemented (- 04/23/2024)

132h - Designated Meeting Place

11. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

The fire safety letter completed on 12/29/23, did not indicate the fire safe areas in the stairwells of the home.

Plan of Correction ***Accept (- 02/21/2024)***

** The Maintenance Director obtained a corrected fire safety letter from the Fire Prevention/Code Administrator on the date of inspection 1/10/24 stating the designated area of refuse presented it to surveyors.*
** On 2/14/24, the Maintenance Director added a check for the compliant fire safety letter to the Preventative Maintenance system to be checked annually in December to ensure compliance with all appropriate designation of fire safe area/meeting place during time of annual drill.*
** The Quality/Risk Management Committee led by the Executive Director on 2/21/24 added an item to the future December Agenda to review the Fire Prevention/Code administrator letter for area of refuge and obtain and updated letter by 2/29/24.*

Licensee's Proposed Overall Completion Date: *02/22/2024*

Implemented (- 04/23/2024)

183d - Prescription Current

12. 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

Resident #3 is prescribed tab take one tablet by mouth every day. The medication was discontinued on , however, the medication was in the medication cart.

Plan of Correction ***Accept (- 02/21/2024)***

** Resident Service Director removed and destroyed Resident #3 discontinued medication on*
** Resident Service Director audited all carts for any discontinued medications by 1/31/24. Any issues found were corrected immediately.*
** The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication controls-Access, Storage, and Labeling by 3/15/24.*
**The Resident Services Director/designee will audit medication carts weekly starting 2/26/24 and continuing for next 90 days for any expired medications.*

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

183d Prescription Current *(continued)*

Implemented (- 04/23/2024)

185a Implement Storage Procedures

13. Requirements

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

Description of Violation

Resident #3 is prescribed tablet take 1 tablet by mouth every morning. The resident was not administered this medication on However, the medication was indicated as being administered on the resident's January 2024, medication administration record.

Plan of Correction ***Accept (- 02/21/2024)***

** Resident #3 medication was ordered on 1/16/24 and was started within 24 hours of receiving medication.*
** Resident Service Director/designee will complete audit of all prescribed orders to ensure medication is available in medication carts by 3/15/2024. Any issues found will be corrected immediately if able to be corrected, and if not able to be corrected, documented utilizing a POC tie back tool to document what was found but could not be corrected and attach it in the resident record.*
** The Regional Care Director will provide training to the Executive Director/designee and the Resident Services Director/designee on the med cart audit process, triple check process, and ordering and receiving medication policy MED-0003-03 by 3/1/24 to ensure understanding of policies and processes related to ordering and receiving medications. The Resident Service Director/designee will conduct in-service on this training to medication staff by 3/15/24.*
** The Resident Service Director/designee will review triple checks daily and med cart audits weekly starting 2/26/24 and continuing for 90 days to ensure proper medication reordering and timely receipt of medications.*

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

Implemented (- 04/23/2024)

187c Refusal of Medication

14. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #3 has refused the administration of multiple medications on multiple dates to include the following.
Resident #3 is prescribed tablet take one tab by mouth every day. The resident refused the administration of this medication on . However, the home failed to notify the prescribing physician.
Resident #3 is prescribed tablet 1 tab by mouth twice daily. The resident refused the administration of this medication on . However, the home failed to notify the prescribing physician.

Resident #4 has refused the administration of multiple medications on multiple dates to include the following.

187c - Refusal of Medication (continued)

Resident #4 is prescribed [redacted] tablet 1 tab by mouth every evening. The resident refused the administration of this medication on [redacted]. However, the home failed to notify the prescribing physician.
Resident #4 is prescribed [redacted] tablet 2 tabs by mouth every day. The resident refused the administration of this medication on [redacted] However, the home failed to notify the prescribing physician.

Resident #5 is prescribed [redacted] tablet 2 tabs by mouth twice daily. The resident refused the administration of this medication on [redacted] However, the home failed to notify the prescribing physician.

Plan of Correction ***Accept ([redacted] - 02/21/2024)***

** Resident Service Director/designee notified physicians of Resident #3, Resident #4 and Resident #5 medication refusal to the physician by 1/16/24.*
** Resident Service Director/designee will complete audit of January 2024 and February 2024 Electronic Medication Administration Record and to ensure physician notification of all residents refused medication by 3/1/24.*
** The Regional Care Director will provide training by 3/1/24 to the Executive Director/designee and Resident Service Director/designee on the reporting process for medication refusals to the physician. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 3/15/24.*
** The Executive Director and Resident Service Director/designee will review Electronic Medication Administration Record weekly starting 2/26/24 and continuing for next 90 days to ensure proper physician notification of medication refusals.*

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

Implemented ([redacted] - 04/23/2024)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident #3 is prescribed [redacted] tablet take one tablet by mouth every morning. However, the resident was not administered this medication on multiple dates to include [redacted], the medication was not in the home.

Plan of Correction ***Accept ([redacted] 02/21/2024)***

** Resident #3 medication was ordered on [redacted] and was started within 24 hours of receiving medication.*
** Resident Service Director/designee will complete audit of all prescribed orders to ensure medication is available in medication carts by 3/15/24. Any issues found will be corrected immediately if able to be corrected, and if not able to be corrected, documented by utilizing a POC tie back tool to document what was found but could not be corrected and attach it in the resident record.*
** The Regional Care Director will provide training to the Executive Director/designee and Resident Services Director/designee on the med cart audit process, triple check process, and ordering and receiving medication policy MED-0003-03 by 3/1/2024 to ensure understanding of policies and processes related to ordering and receiving medications. Resident Service Director/designee will conduct in-service on this training to medication staff by 3/15/24.*
** The Resident Services Director/designee will review triple checks daily and med cart audits weekly starting*

187d - Follow Prescriber's Orders (continued)

2/26/24 and continuing for next 90 days to ensure proper medication reordering and timely receipt of medications.

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

Implemented (- 04/23/2024)

224c - Preadmission Screening

16. Requirements

2600.
224.c. The preadmission screening shall be completed by the administrator or designee. If the resident is referred by a State-operated facility, a county mental health and intellectual disability program, a drug and alcohol program or an area agency on aging, a representative of the referral agent may complete the preadmission screening.

Description of Violation

Resident #4 date of admission , did not have a preadmission screening form completed.

Plan of Correction ***Accept - 02/21/2024)***

** Resident Service Director will complete audit of all move-in prescreens for current residents by 3/15/24. All prescreens not completed within the regulatory guideline's timeframe will be documented by utilizing a POC tie back tool to document what was found but could not be corrected retroactively and attach it in the resident record.*
** Regional Care Director will provide education to the Executive Director and Resident Services Director to ensure compliance with regulation 2600.224.c and to ensure Preadmission screening is completed within the required timeframe according to regulations and Atria expectations.*
** Regional Care Director will provide additional training to the Executive Director and Resident Services Director/designee on move in process to ensure understanding of requirements for obtaining Preadmission screening within 30 days prior to admission to ensure that the needs of the resident can be met by the services provided in the community by 3/1/24.*
** Executive Director will meet with Resident Service Director/designee weekly starting 2/26/24 and continuing for the next 90 days to review preadmission screening for all new admissions to ensure compliance with regulation 2600.224.c, Resident Service Director will be responsible to ensure continue compliance with regulations.*

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

Implemented - 04/23/2024)

225a - Assessment 15 Days

17. 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 #4 was admitted into the home on however, the home did not complete and assessment of care needs until

Plan of Correction ***Accept - 02/21/2024)***

** Resident Service Director will complete audit of all move- in assessments/service plan for current residents by*

225a - Assessment 15 Days (continued)

3/15/24. All assessments not completed within the regulatory guideline's timeframe will be documented by utilizing a POC tie back tool to document what was found but could not be corrected retroactively and attach it in the resident record.
** Regional Care Director will provide education to the Executive Director and Resident Service Director/designee by 3/1/24 on the importance of ensuring resident assessments are completed and signed within 15 days of admission in accordance with regulation 2600.225.a*
** Executive Director will meet with Resident Service Director/designee weekly starting 2/26/24 and continuing for the next 90 days to review all new resident assessments to ensure they are completed and signed per regulation 2600.225.a.*

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

Implemented (- 04/23/2024)

225c - Additional Assessment

18. 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.

Description of Violation

Resident #1 support plan for the resident's care needs for fall risk completed , does not address the resident care need for supplemental service staff person who provide activities of daily living, incontinence care, am/pm care, and cue to feed as being provided to the resident by a supplemental staff person.

Plan of Correction ***Accept (- 02/21/2024)***

** Resident Service Director completed new assessment for Resident #1 on to ensure the service plan/support plan documents addressed the private caregiver.*
** Resident Service Director/designee will complete audit of the current residents' service plan/support plan by 3/15/24, to ensure service plan/support plan captures the services of a private caregiver. Any issues found during the audit will be addressed immediately,*
** Regional Care Director will provide additional training to the Executive Director and Resident Service Director/designee by 3/1/24 to ensure service plans/support plans capture the services of the caregiver.*
** Executive Director will meet with Resident Service Director/designee weekly starting 2/26/24 and continuing for the next 90 days to review all new support plans to ensure plans/support plans have documentation/address the services of a private caregiver.*

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

Implemented - 04/23/2024)

227c - Support Plan Revision

19. Requirements

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

Description of Violation

Resident #1's most recent support plan completed did not address a personal care need for the resident's fall

227c - Support Plan Revision (continued)

risk. However, resident #1 has had falls on multiple dates to include [redacted].

Plan of Correction ***Accept (- 02/21/2024)***

** Resident Service Director completed new service plan/support plan for Resident #1 on to include fall risk.*
** Resident Service Director/designee will complete an audit of the current residents' service plan/support plans by 3/15/24, to ensure service plan/support plan document/address the resident fall risk accurately. Any issues found during the audit will be addressed immediately.*
** Regional Care Director will provide additional training to the Executive Director and Resident Services Director/designee by 3/1/24 to ensure service plan/support plans document/address resident fall risk.*
** Executive Director will meet with Resident Services Director/designee weekly starting 2/26/24 and continuing for next 90 days to review all new support plans to ensure service plans/support plans have documentation or address resident fall risk.*

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

Implemented (- 04/23/2024)