

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

May 14, 2024

[REDACTED], ADMINISTRATOR
CLARKS SUMMIT AID II OPCO LLC
150 EDELLA ROAD
CLARKS SUMMIT, PA, 18411

RE: WILLOWBROOK PLACE
150 EDELLA ROAD
CLARKS SUMMIT, PA, 18411
LICENSE/COC#: 22659

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/14/2024 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]
Acting Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: WILLOWBROOK PLACE **License #:** 22659 **License Expiration:** 01/08/2025
Address: 150 EDELLA ROAD, CLARKS SUMMIT, PA 18411
County: LACKAWANNA **Region:** NORTHEAST

Administrator

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

Legal Entity

Name: CLARKS SUMMIT AID II OPCO LLC
Address: 150 EDELLA ROAD, CLARKS SUMMIT, PA, 18411
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 06/10/1998 **Issued By:** L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 47 **Waking Staff:** 35

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 03/14/2024

Inspection Dates and Department Representative

03/14/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 80 **Residents Served:** 33

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:** 33
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 14 **Have Physical Disability:** 0

Inspections / Reviews

03/14/2024 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/25/2024

05/03/2024 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 05/14/2024
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 05/10/2024

Inspections / Reviews *(continued)*

05/08/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/14/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/14/2024

05/14/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/14/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department’s personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident # 1 receives blood sugar checks 3x daily. Resident # 1 did not receive checks on [REDACTED], [REDACTED] per the resident’s MAR. These missed readings were not reported to the Department.

Plan of Correction

Accept [REDACTED] - 04/29/2024)

- The week of 4/15/2024, RWD (Resident Wellness Director) verified Resident #1 blood sugar checks with resident’s primary care physician then cross referenced the MAR (Medical Medication Records) for accuracy of blood sugar checks.
- The week of 4/15/2024, RWD (Resident Wellness Director) audited the MAR for accuracy of blood sugar check and found no discrepancies with regulation 2600.16(c). Documentation will be retained within the community. (Exhibit 1 – Audit)
- Starting the week of 4/22/2024, ED, RWD or designee will re-educate all direct care staff on reporting incidents or condition to the Department’s personal care home regional office or the personal care home office hotline within 24 hours (Exhibit 2 – In-service)
- Starting the week of 5/6/2024, ED, RWD or designee will audit MAR’s weekly x 4 weeks to ensure compliance with regulation 2600.16(c) Documentation will be retained within the community. (Exhibit 3 – Audit)
- On 5/10/2024, Rosemary Takas (Trainer) will re-educate all direct care staff who are MedTech’s on Diabetes Management, Insulin Administration and Blood Glucose Monitoring and provide certifications and re-certifications on requirements set within regulation 2600.16(c).
- Starting the week of 5/6/2024, ED and RWD will re-educate all staff on all Abuse Reporting Covered by Law under regulations 2600.15. Documentation will be retained within the community. (Exhibit 4 – In-Service)
- Starting in July 2024, ED, RWD or designee will discuss the results of resident charting compliance during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary.

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

Implemented [REDACTED] - 05/14/2024)

17 - Record Confidentiality

2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident’s designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident’s power of attorney for health care or health care proxy or a resident’s designated person, or if a court orders disclosure.

Description of Violation

On 3/14/24, Licensing inspection summary from 7/27/23 was in the home’s inspection binder located at the front

17 Record Confidentiality (continued)

reception desk, The resident privacy coding was attached to the Licensing Inspection Summary.

Plan of Correction

Accept () - 05/07/2024)

- On 4/18/2024, ED audited license inspection summary in the facilities inspection binder located at the front reception desk and found no discrepancies with regulation 2600.17.
- On 4/18/2024, ED and designee will be re educated on requirements set within regulation 2600.17. Documentation will be retained within the community. (Exhibit 1 In service)
- Starting the week of 5/6/2023, ED or designee will audit licensing inspection summary files weekly x 4 weeks to ensure confidentiality of resident records to maintain compliance with regulation 2600.17. Documentation will be retained within the community. (Exhibit 2 Audit Tool).
- Starting in July 2024, ED or designee will discuss the results of the audit during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024)

51 - Criminal Background Check

3. 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

Direct Care staff A was hired on [redacted]. A background check was not completed until [redacted]. Direct care staff A was completing unsupervised direct care prior to [redacted]. The exact date the staff member began direct care is unknown by the home.

Plan of Correction

Accept () - 04/29/2024)

- Starting the week of 5/13/2023, ED and designee will be re educated on requirements set within regulation 2600.51 where criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act. Documentation will be retained within the community. (Exhibit 1 In service)
- Starting the week of 5/13/2024, ED or designee will audit resident files weekly x 4 weeks to ensure Criminal history checks records to maintain compliance with regulation 2600.51. Documentation will be retained within the community. (Exhibit 2 Audit Tool).
- Starting in July 2024, ED or designee will discuss the results of the audit during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

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

Implemented () - 05/14/2024)

54a - Direct Care Staff

4. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

The home did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry for direct care staff A hired [REDACTED]

Repeat Violation 9/5/23

Plan of Correction

Accept [REDACTED] - 05/07/2024)

- On 3/27/2024, ED received a waiver from Department of Human Services for Staff Person A in regards to regulation 2600.54a. Documentation will be retained within the community. (Exhibit 1 – Document)
- On 4/18/2024, ED and designee re-educated on requirements set within regulation 2600.54a. Documentation will be retained within the community. (Exhibit 2 – In-service)
- Starting the week of 5/6/2024, ED or designee will audit 2 new direct care staff person files weekly x 4 weeks to ensure the employee has a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry to maintain compliance with regulation 2600.54a. Documentation will be retained within the community. (Exhibit 2 – Audit Tool).
- Starting in July 2024, ED or designee will discuss the results of the audit during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented [REDACTED] - 05/14/2024)

65g - Annual Training Content

5. 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.
- 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff person B did not receive fire safety training by a fire safety expert and The Older Adult Protective Services Act in training year 2023.

Plan of Correction

Accept [REDACTED] - 05/07/2024)

- On 4/22/2023, ED and Facilities Manager re-educated on requirements set within regulation 2600.65(g). Direct Staff B was re-educated on all regulations of 2600.65(g) including, Fire Safety and The Older Adult Protective Services. (Exhibit 1.1) Documentation will be retained within the community. (Exhibit 1 – In-service)
- 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.

65g - Annual Training Content (continued)

(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.

(3) Resident rights.

(4) The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

(5) Falls and accident prevention.

(6) New population groups that are being served at the home that were not previously served, if applicable.

• Starting the week of 5/6/2024, ED or designee will audit 2 new direct care staff person files weekly x 4 weeks to ensure direct care staff trained and oriented to maintain compliance with regulation 2600.65(g). Documentation will be retained within the community. (Exhibit 2 – Audit Tool).

• Starting in July 2024, ED or designee will discuss the results of the audit during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024)

85d - Trash Receptacles

6. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

In the main kitchen there were two trash cans not in current use that were uncovered.

Plan of Correction

Accept () - 05/08/2024)

• On 3/15/2024, ED and Facilities Manager educated staff on requirements set within regulation 2600.85(d). It was effectively reinforced, and physically shown, that all garbage can lids in kitchen and bathrooms must be covered at all times to prevent penetration of rodents and insects and will be monitored daily.

• Starting week of 5/6/2024, ED and Facilities Manager will re-educate staff on requirements set within regulation 2600.85(d). Documentation will be retained within the community. (Exhibit 1 – In-service)

• Starting in July 2024, ED or designee will discuss the results of the training during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024)

91 - Telephone Numbers

7. 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 outgoing landlines in the home's dining room, private dining room, and resident room #123 did not have the

91 - Telephone Numbers (continued)

required emergency telephone numbers posted near the telephone.

Plan of Correction

Accept () - 05/08/2024)

- On 3/15/2024, ED and Facilities Manager walked the property with laminated emergency phone number list and zip tied the list to the phone cord on every resident's phone and every phone a resident would have access.
- Starting week of 5/6/2024, ED and Facilities Manager will re-educate on requirements set within regulation 2600.91. Documentation will be retained within the community. (Exhibit 1 – In-service)
- Starting week of 5/6/2024, ED and Facilities Manager will audit facilities for compliance of regulation 2600.91. Documentation will be retained within the community. (Exhibit 2 – Audit)
- Starting in July 2024, ED or designee will discuss the results of the training during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024)

101j7 - Lighting/Operable Lamp

8. 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.

Description of Violation

Resident room 221 did not have a bedside lamp within reach of the residents bed.

Plan of Correction

Accept () - 05/07/2024)

- On 3/15/2023, ED and Facilities Manager moved the light fixture and bedside table to primary location, in reach of the bed. Spoke with resident and family member about the issue.
- Starting week of 5/6/2024, ED and Facilities Manager will audit facilities for compliance of regulation 2600.101(j). Documentation will be retained within the community. (Exhibit 2 – Audit)
- Starting in July 2024, ED or designee will discuss the results of the training during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024)

103i - Outdated Food

9. Requirements

2600.

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

Description of Violation

Located in the freezer was a plastic container with a Ziploc bag that contained chicken. The bag or container was not dated. In the refrigerator was a container with a hotdog, 2 salads, and a bag of chicken that appeared to be thawing. None of these items were dated.

103i - Outdated Food (continued)

Plan of Correction

Accept () - 05/08/2024

- On 3/15/2024, ED and Facilities Manager spoke with all dietary staff on dating each and every item that is placed in any refrigerator or freezer, before it is placed in the cooling units, as well as, audited current items in the cooling units.
- Starting week of 5/6/2024, ED and Facilities Manager will re-educate all dietary staff on requirements set within regulation 2600.103(i). Documentation will be retained within the community. (Exhibit 1 – In-service)
- Starting week of 5/6/2024, ED and Facilities Manager will audit dietary facilities for compliance of regulation 2600.103(i). Documentation will be retained within the community. (Exhibit 2 – Audit)
- Starting in July 2024, ED or designee will discuss the results of the training during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024

132a - Monthly Fire Drill

10. Requirements

2600.

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

Description of Violation

There was no drill conducted in March 2023. Per the Administrator, the home had a COVID outbreak in March 2023, but could not provide verification that they contacted the Northeast Regional Director for further guidance as required.

Plan of Correction

Accept () - 05/07/2024

- Starting week of 5/6/2024, ED and Facilities Manager will re-educate on requirements set within regulation 2600.132(a). Documentation will be retained within the community. (Exhibit 1 – In-service)
- Starting week of 5/6/2024, ED and Facilities Manager will audit facility for compliance of regulation 2600.132(a). Documentation will be retained within the community. (Exhibit 2 – Audit)
- Starting in July 2024, ED or designee will discuss the results of the training during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024

132d - Evacuation

11. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's most recent fire safety inspection was completed on 11/2/23. The previous inspection was completed

132d Evacuation (continued)

9/14/22, more than one year previous.

Plan of Correction

Accept () - 05/07/2024)

- Fire safety plan will be monitored by Ed and Facility Manager. A TELS electronic facilities management system is already in place and will alert prior to when all inspections are due.
- Starting week of 6/3/2024, ED and Facilities Manager will re educate on requirements set within regulation 2600.132(d). Documentation will be retained within the community. (Exhibit 1 In service)
- Starting week of 6/3/2024, ED and Facilities Manager will audit facility for compliance of regulation 2600.132(d). Documentation will be retained within the community. (Exhibit 2 Audit)
- Starting in July 2024, ED or designee will discuss the results of the training during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024)

132f - Alternate Exit Routes

12. Requirements

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

Description of Violation

The fire drills conducted during from January 2023 through December 2023, the only exit route used was documented as "Front."

Plan of Correction

Accept () - 05/07/2024)

- Starting week of 5/6/2024, ED and Facilities Manager will run a fire drill each month rotating through shifts in a three month cycle and will use different evacuation points each time and will track.
- Starting week of 5/6/2024, ED and Facilities Manager will re educate on requirements set within regulation 2600.132(f). Fire inspections will be conducted within a twelve month timeframe. Documentation will be retained within the community. (Exhibit 1 In service)
- Starting week of 5/6/2024, ED and Facilities Manager will audit facility for compliance of regulation 2600.132(f). Documentation will be retained within the community. (Exhibit 2 Audit)
- Starting in July 2024, ED or designee will discuss the results of the training during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024)

144c1 - Smoking Area Guidelines

13. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

144c1 Smoking Area Guidelines (continued)

Description of Violation

The was a pack of cigarettes, a lighter, and metal bucket with multiple cigarette butts located on the patio near the home's entrance. The area is labeled a Non Smoking area and is not the home's designated smoking area.

Plan of Correction

Accept (█) - 05/08/2024)

- Starting week of 5/6/2024, ED and Facilities Manager will re educate on requirements set within regulation 2600.144(c)1. Documentation will be retained within the community. (Exhibit 1 In service)
- Starting week of 5/6/2024, ED and Facilities Manager will audit facility for compliance of regulation 2600.144(c)1. Documentation will be retained within the community. (Exhibit 2 Audit)
- Starting in July 2024, ED or designee will discuss the results of the training during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary based on three consecutive months of auditing. Documentation will be retained within the community.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented (█) - 05/14/2024)

183b - Meds and Syringes Locked

14. 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

During inspection of room 221, a pill box was noticed to be sitting on the dresser. Resident #3 indicated that Resident #3's daughter fills the pill box and leaves on the dresser. Resident #3 stated that is where the pill box stays and Resident #1 indicated that the Resident door does not get locked when the room is vacated.

Plan of Correction

Accept (█) - 05/07/2024)

- On 3/15/2024, ED and Resident Wellness Director spoke with resident and family concerning the pill box of over the counter medication and stated that we will administer all medications that remain on site and removed medications and pill container from the resident's apartment.
- Starting the week of 5/3/2024, ED, RWD and direct care staff will be re educated on requirements set within regulation 2600.183(b). Documentation will be retained within the community. (Exhibit 1 In service)
- Starting the week of 5/3/2024, ED, RWD or designee will audit facility weekly x 4 weeks to ensure compliance with regulation 2600.183(b) (Exhibit 2 Audit)
- Starting in July 2024, ED, RWD or designee will discuss the results of resident charting compliance during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented (█) - 05/14/2024)

185a - Implement Storage Procedures

15. Requirements

2600.

185a - Implement Storage Procedures (continued)

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 # 2 glucometer is not calibrated for the correct date and time. At [REDACTED], the resident's glucometer reflected a date/time of [REDACTED].

Plan of Correction

Accept ([REDACTED]) - 05/07/2024)

- On 3/15/2024 Resident Wellness Director recalibrated the glucose monitor to the correct date and time.
- Starting the week of 5/3/2024, ED, RWD and direct care staff will be re-educated on requirements set within regulation 2600.185(a). Documentation will be retained within the community. (Exhibit 1 – In-service)
- Starting the week of 5/3/2024, ED, RWD or designee will audit facility weekly x 4 weeks to ensure compliance with regulation 2600.185(a) (Exhibit 2 – Audit)
- Starting in July 2024, ED, RWD or designee will discuss the results of resident charting compliance during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented ([REDACTED]) - 05/14/2024)

187d - Follow Prescriber's Orders

16. Requirements

2600.

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

Description of Violation

Resident # 1 receives blood sugar checks 3x daily. Resident # 1 did not receive checks on [REDACTED] at [REDACTED], [REDACTED].

Plan of Correction

Accept ([REDACTED]) - 05/03/2024)

- The week of 4/15/2024, RWD (Resident Wellness Director) verified Resident #1 blood sugar checks with resident's primary care physician then cross referenced the MAR (Medical Medication Records) for accuracy of blood sugar checks.
- The week of 4/15/2024, RWD (Resident Wellness Director) audited the MAR for accuracy of blood sugar check and found no discrepancies with regulation 2600.187(d). Documentation will be retained within the community. (Exhibit 1 – Audit)
- Starting the week of 5/3/2024, ED, RWD and direct care staff will be re-educated on requirements set within regulation 2600.187(d). Documentation will be retained within the community. (Exhibit 1 – In-service)
- Starting the week of 5/3/2024, ED, RWD or designee will audit facility weekly x 4 weeks to ensure compliance with regulation 2600.187(d) (Exhibit 2 – Audit)
- Starting in July 2024, ED, RWD or designee will discuss the results of resident charting compliance during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary.

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

Implemented ([REDACTED]) - 05/14/2024)

190b - Insulin Injections

17. Requirements

2600.

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 A, Staff B, and Staff C completed diabetic training on 1/20/23, more than 12 months ago.

Plan of Correction

Accept () - 05/07/2024

- On 5/10/2024, () (Trainer) will re-educate all direct care staff who are MedTech's on Diabetes Management, Insulin Administration and Blood Glucose Monitoring and provide certifications and re-certifications on requirements set within regulation 2600.190(b) Diabetic certifications will be on file at the facility. Staff members A, B and C will not administer insulin until training is completed.
- On the week of 5/13/2024, ED, RWD or designee will audit direct care staff training to ensure future compliance with regulation 2600.190(b) (Exhibit 2 – Audit)
- Starting in July 2024, ED, RWD or designee will discuss the results of resident charting compliance during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary.

Licensee's Proposed Overall Completion Date: 05/03/2024

Implemented () - 05/14/2024

227d - Support Plan Medical/Dental

18. 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 # 3's RASP, dated () does not have documentation of when resident began receiving hospice services. The resident's RASP also states that resident cannot self-administer medications but currently self-administers some medications.

Resident # 4's RASP, dated (), does not contain any documentation regarding the resident's use of a bed cane.

Plan of Correction

Accept () - 05/03/2024

- On the week of 3/18/2024 RWD corrected RASP on Resident #3 and #4. Documentation will be retained within the community. (Exhibit 1 and 2 – RASP's)
- Starting week of 5/3/2023, ED and RWD will re-educate on requirements set within regulation 2600.227(d). Documentation will be retained within the community. (Exhibit 2 – In-service)
- Starting the week of 5/3/2024, RWD or designee will audit RASP's and clinical documentation to ensure future compliance with regulation 2600.227(d) (Exhibit 3 – Audit)

227d Support Plan Medical/Dental (continued)

- Starting in July 2024, ED, RWD or designee will discuss the results of resident charting compliance during the monthly Quality Improvement meetings. Quality improvement committee will determine if continued auditing is necessary.

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

Implemented ([REDACTED] - 05/14/2024)