



CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: JUNE 5, 2024

[REDACTED]
KJ Bethel Park LLC
[REDACTED]

RE: The Sheridan at Bethel Park
License/COC #: 449482

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, Office of Long-Term Living licensing inspections on January 2, 2024, February 22, 2024, February 23, 2024, March 8, 2024, March 19, 2024, March 20, 2024, April 2, 2024, and April 5, 2024, of the above facility, the citations specified on the enclosed Licensing Inspection Summaries (LISs) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 449482) to operate the above facility. The Department's decision to revoke your license is based on the violations attached to this notice, mistreatment or abuse of residents being cared for in the facility, failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items and is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation).

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.


55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
17	III	119	\$3	\$357	15 calendar days from mailing date of this letter
25(b)	III	119	\$3	\$357	15 calendar days from mailing date of this letter
141(b)(1)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
183(d)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
184(a)	II	119	\$5	\$595	15 calendar days from mailing date of this letter
185(a)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
187(d)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
183(e)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
187(a)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
191	III	119	\$3	\$357	15 calendar days from mailing date of this letter
225(a)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
225(c)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
227(a)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
227(c)	III	119	\$3	\$357	15 calendar days from mailing date of this letter
227(g)	II	119	\$5	\$595	5 calendar days from mailing date of this letter

231(b)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
231(e)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
234(a)	II	119	\$5	\$595	5 calendar days from mailing date of this letter
234(d)	II	119	\$5	\$595	5 calendar days from mailing date of this letter

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

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

If you disagree with the decision to REVOKE your license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:


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

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

The enclosed violation reports specify plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. The Sheridan at Bethel Park is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes).

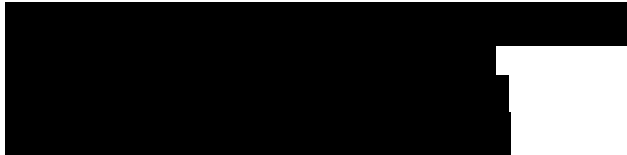
Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: *THE SHERIDAN AT BETHEL PARK* License #: *44948* License Expiration: *06/01/2024*
Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA 15234*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *KJ BETHEL PARK LLC*
Address: [REDACTED]
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *12/13/2019* Issued By: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *160* Waking Staff: *120*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Incident, Fine* Exit Conference Date: *01/02/2024*

Inspection Dates and Department Representative

01/02/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* Residents Served: *122*

Secured Dementia Care Unit

In Home: *Yes* Area: *MC1 & MC2* Capacity: *40* Residents Served: *33*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *121*
Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *38* Have Physical Disability: *3*

Inspections / Reviews

01/02/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/18/2024*

Inspections / Reviews (*continued*)

02/23/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 04/12/2024
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/01/2024

04/09/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 04/12/2024
Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 04/16/2024

05/08/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: 04/12/2024
Reviewer: [REDACTED] Follow-Up Type: Exception

17 - Record Confidentiality

1. 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

At approximately 9:15 a.m., a white three-ring binder containing confidential resident information for numerous residents was unlocked, unattended, and accessible in the private conference room, including preadmission screenings and medical evaluations for residents #1 and #2.

Repeat violation 6/27/23 et al

Plan of Correction

Accept [redacted] - 04/02/2024)

Confidential items were removed at the time of inspection.

ED or designee to monitor the entire home daily to confirm confidential information is secure. A tracker was put into place on 2/8/24 and will remain in place until 3/31/24, attached for review.

An in-service was conducted for management on 2/14/24, all other staff will receive in-serving at the monthly All-Staff meeting on 2/21/24. A review of the community's compliance and any additional next steps will be added to next QA meeting minutes.

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

Not Implemented [redacted] - 5/8/24)

25b - Contract Signatures

2. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The contract for resident #3, dated 10/2/23, was not signed by the resident.

The contract for resident #4, dated 10/27/23, was not signed by the resident.

Repeat violation 5/3/23 et al

Plan of Correction

Accept [redacted] - 04/09/2024)

Leases for resident #3 and #4 were signed on 2/9/24. Signature pages attached for review.

An audit was conducted the week of 2/5/24 to confirm that all other leases have resident signatures.

All staff involved in the admission process reeducated on this requirement, in-service sheet attached.

--Per Executive Director, training completed on 2/29/24. - [redacted] /9/24

Implementation of a resident file tracker has been put into place that will ensure all contracts are signed by all

25b - Contract Signatures (continued)

required parties at the time of admission. Tracker will be up to date by 3/20/24.

Proposed Overall Completion Date: 03/20/2024

Licensee's Proposed Overall Completion Date: 03/20/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)

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

The enabler mobility device on resident #5's bed was not secured to the bedframe and could be fully removed. Also, there was an opening measuring approximately 10 ½" by 8 ½" that is uncovered, posing an entrapment hazard.

The enabler mobility device on resident #6's bed was not well secured to the bedframe, and the device could be lifted approximately 3" and moved approximately 6" to the left and right. Also, there was an opening measuring approximately 10 ½" by 8 ½" that is uncovered, posing an entrapment hazard.

Plan of Correction

Accept [REDACTED] - 04/09/2024)

Resident #5's bed was secured to the bed frame. The opening that was reported has been covered, pictures attached.

Residents #6's bed was secured to the bed frame. The opening that was reported has been covered, picture attached.

Audits were conducted starting the week of 1/22/24 and weekly thereafter to confirm that resident's equipment was installed properly, there were no gaps and that equipment was covered. Audits attached.

A process for daily monitoring of the devices put in place for care staff. Documentation will be captured within the home's eMAR system.

All staff to receive education on the home's policies and procedures for ensuring safety of bedside mobility devices by 3/15/24. Documentation of this training to be kept.

Licensee's Proposed Overall Completion Date: 03/15/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)

103e - Left Overs**4. Requirements**

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

Multiple undated foods were in the walk-in cooler, including deli-style ham turkey and roast beef wrapped in plastic.

103e - Left Overs (continued)

Repeat violation 6/27/23 et al

Plan of Correction

Accept [REDACTED] 04/09/2024)

Items not labeled at the time of inspection were immediately discarded.

Director of Dining Services and culinary staff in-serviced on this required, training attached.

--Per Executive Director, training completed on 2/13/24. [REDACTED] 4/9/24

After the site inspection, audits started on a daily basis to monitor items in walk-in cooler for regulatory compliance. This twice daily audit continued through the month of February and will move to daily thereafter as a continued best practice. Audits attached.

The Director of Culinary Services will also conduct a weekly audit in addition to the staff's daily audits [REDACTED]

DIRECTED: Weekly monitoring walk-throughs by the Director of Culinary Services will be completed. Documentation will be kept. [REDACTED] 4/9/24

Proposed Overall Completion Date: 04/15/2024

Not Implemented [REDACTED] - 5/8/24)

Licensee's Proposed Overall Completion Date: 04/15/2024

Licensee's Proposed Date for POC Implementation

103g - Storing Food

5. Requirements

2600.

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

Description of Violation

There were multiple uncovered trays of foods in the walk-in cooler, to include:

- 6 large trays each containing 3 pounds of bacon
- A large tray of sausage links
- A large tray with various unbaked pastries

Repeat violation 6/27/23 et al

Plan of Correction

Accept [REDACTED] 04/09/2024)

Items not covered at the time of inspection were immediately discarded.

Director of Dining Services and culinary staff in-serviced on this required, training attached.

-- Per Executive Director, training completed on 2/13/24. -- [REDACTED] 4/9/24

The Director of Culinary Services will also conduct a weekly audit in addition to the staff's daily audits through the month of March.

After the site inspection, audits started on a daily basis to monitor items in walk-in cooler for regulatory compliance. This twice daily audit continued through the month of February and will move to daily thereafter as a continued

103g - Storing Food (continued)

best practice. Audits attached.

DIRECTED: Weekly monitoring walk-throughs by the Director of Culinary Services will be completed. Documentation will be kept. [REDACTED] 4/9/24

Licensee's Proposed Overall Completion Date: 04/15/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)

131e - Accessible Extinguishers

6. Requirements

2600.

131.e. Fire extinguishers shall be accessible to staff persons. Fire extinguishers shall be kept locked if access to the extinguisher by a resident could cause a safety risk to the resident. If fire extinguishers are kept locked, each staff person shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

Description of Violation

The fire extinguisher in the server's alley located in the main dining room was blocked by a stainless-steel table and a chair and was inaccessible. The door to the cabinet containing the extinguisher could only be opened approximately 4 inches.

Plan of Correction

Accept ([REDACTED] 02/23/2024)

Table blocking the extinguisher area was moved at the time of inspection, picture of area attached. All extinguisher areas have been checked to confirm that they are accessible to staff persons and emergency personnel.

Director of Plant Ops conducted an audit of all fire extinguishers in the community the week of 2/11/24 to confirm no other extinguishers are blocked in the community in any way.

Department heads in-serviced on this regulation during monthly department head meeting on 2/14/24, attached. All other community staff scheduled to receive in-service on 2/21/24 during monthly all-staff meeting.

Licensee's Proposed Overall Completion Date: 02/21/2024
Licensee's Proposed Date for POC Implementation

Implemented [REDACTED] - 05/08/2024)

141b1 - Annual Medical Evaluation

7. Requirements

2600.

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

Description of Violation

Resident #6's last medical evaluation was completed on [REDACTED] 22.

Resident #7,'s last medical evaluation was completed on [REDACTED] 22.

Resident #8's last medical evaluation was completed on [REDACTED] 22.

141b1 - Annual Medical Evaluation (continued)

Repeat violation 3/22/23 et al; and 6/27/23 et al

Plan of Correction

Accept (████) - 04/09/2024)

Resident #6's medical evaluation was updated on █████/15/23, documentation attached for review.

Resident #7's medical evaluation was updated on █████/24, documentation attached for review.

Resident #8 passed away on █████/23, unable to update DME.

An audit of annual medical evaluations was completed on 1/18/24. As of 2/13/24 all DME are up to date and met the requirement of this regulation.

Community's electronic health record system tracks annual assessments and alerts on site time of due dates which triggers the need to complete an annual DME. New community staff are in plan to monitor this system properly and to ensure medical evaluations are completed timely. Community staff have been in-service on this tracking, how to use and the process for scheduling an annual physician's visit for the completion of this evaluation.

All staff persons involved in obtaining and scheduling medical evaluations have been reeducated on this regulation and on the tracking system. Training documentation attached.

--Per Executive Director, training completed on 3/29/24 and 3/4/24. -████ 4/9/24

Proposed Overall Completion Date: 03/15/2024

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

Not Implemented (████) - 5/8/24)

Licensee's Proposed Date for POC Implementation

183b - Meds and Syringes Locked**8. 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

At approximately 11:20 a.m., a bottle of Tylenol 8 Hour Muscle Aches & Pain Extended Relief and a bottle of Children's Delsym Cough Suppressant were unlocked and accessible in resident #5's bedroom. Resident #5 is not assessed capable to self-administer medications.

Plan of Correction

Accept (████) 04/09/2024)

The medication in Resident #5's apartment was removed at the time of inspection.

Education was provided to the resident and family on requirement for facility to keep all OTC meds on the locked med cart. Follow up education provided immediately after inspection and again on 2/14/24 in writing, attached.

In-servicing for all med techs, which included this regulation, was conducted on 2/6/24. Training record attached.

Written notification of this requirement went to all residents and all responsible parties on 2/13/24, attached.

183b - Meds and Syringes Locked (continued)

A full community audit was conducted by 2/20/24 to confirm that residents on medication administration program did not have any OTC medications stored in their apartments.

On a monthly basis the HWD, AHWD or designee will do a full sweep of all apartments to confirm compliance with this regulation.

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

Not Implemented [REDACTED] - 5/8/24)

183d - Prescription Current

9. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 9/13/23, resident #7 was ordered Guaifenesin 100mg/5ml 473ml, take 20ml (400mg) 3 times daily for 3 days. However, this medication was still stored on the medication cart.

Resident #9 was ordered Humalog Injection Solution 100 unit/ml sliding scale which was discontinued on 12/14/23. The medication was still stored on the cart. Additionally, the insulin pen was dated as being opened on 12/29/23.

Repeat violation 5/3/23 et al; and 6/27/23 et al

Plan of Correction

Accept [REDACTED] - 04/09/2024)

The discontinued medication for Residents #7 and #9 were removed from the cart at the time of inspection.

Medication cart audits were conducted by staff weekly for 4 weeks post inspection. Audits attached.

In-servicing for all med techs, which included this regulation, was conducted on 2/6/24. Training record attached.

Recurring medication cart audits are scheduled with home's partner pharmacy on a bi-monthly basis.

The home has a policy for the destruction of medications for residents' who are no longer in the home or who have discontinued or expired medications. The policy will be reviewed with all staff who manage medications. Training record attached.

The administrator will monitor the medication carts and any other medication storage areas to ensure medications that are expired, discontinued or that belong to residents no longer in the community have been per the home's policy and in accordance to 2600.183j.

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

Not Implemented [REDACTED] - 5/8/24)

184a - Resident's Meds Labeled

10. Requirements

2600.

184a - Resident's Meds Labeled (continued)

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #9 is ordered Oxycodone HCL 5mg, 1 tablet every 6 hours as needed, however, the label indicates 1 tablet every 4 hours as needed.

Resident #9 is ordered Acetaminophen 500mg, 2 tablets every 6 hours as needed, however, the label indicates 325mg, 2 tablets (650mg) every 6 hours as needed.

Repeat violation 3/22/23 et al

Plan of Correction

Directed [REDACTED] 04/09/2024)

Resident #9's medication label and orders did not match, they were reviewed and corrected. Confirmation attached.

Medication cart audits were conducted by staff weekly for 4 weeks post inspection, to ensure compliance. Audits attached.

In-servicing for all med techs, which included this regulation, has been completed. Training record attached.

Next audit to be completed by facility's partner pharmacy is schedule for 2/26/24.

Biweekly audits will be scheduled and completed by the Health & Wellness Director or designee [REDACTED]

DIRECTED: Within 7 days of receipt of the plan of correction and biweekly thereafter - The Health and Wellness Director or designee will complete audits of the medication carts. [REDACTED] 4/9/24

Directed Completion Date: 04/15/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)

185a - Implement Storage Procedures

11. 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 #7 is ordered blood sugar readings daily at 7:00 a.m.

- Resident #7's December 2023 MAR indicates a blood glucose reading of 273; however, there was no corresponding reading in the resident's glucometer.

185a - Implement Storage Procedures (continued)

- Resident #7's glucometer does not display the current date and time when turned on; therefore, it is unable to be confirmed the date and time of glucose testing.

Resident #7 is ordered Lorazepam 0.5mg, one tablet every 4 hours as needed and Morphine Sulfate 20mg/1ml sol 30ml, take 0.25ml (5mg) every 4 hours as needed. However, these medications were not available in the home.

Resident #9 is ordered Senna 8.6mg, 2 tablets at bedtime/8:00 p.m. as needed. However, this medication was not available in the home.

Repeat violation 3/22/23 et al; and 6/27/23 et al

Plan of Correction

Directed [REDACTED] - 04/09/2024)

Resident #7's medications identified as unavailable on 1/2/24. This PRN medication was delivered to the community, confirmation documentation attached.

Audit conducted and to be completed by 2/20/24 to confirm all PRN medications are available in the community, attached for review.

In-servicing for all med techs, which included this regulation, has been completed. Training record attached.

Biweekly audits will be scheduled and completed by the Health & Wellness Director or designee [REDACTED]

DIRECTED: Within 7 days of receipt of the plan of correction and biweekly thereafter - The Health and Wellness Director or designee will complete audits of the medication carts. [REDACTED] 4/9/24

Directed Completion Date: 04/15/2024

Not Implemented [REDACTED] - 5/8/24)

Licensee's Proposed Date for POC Implementation

187d - Follow Prescriber's Orders**12. Requirements**

2600.

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

Description of Violation

Resident #7 is ordered blood sugar readings daily at 7:00 a.m.; however, on 12/13/23, the resident's glucometer did not have a blood glucose reading and the MAR was blank.

Repeat violation 3/22/23 et al; 5/3/23 et al; and 6/27/23 et al

Plan of Correction

Accept [REDACTED] - 04/09/2024)

Resident #7 did not have a recorded blood glucose reading on 12/13/24. The MAR and glucometer readings have been reviewed since that date and no reading has been missed.

The med tech working at the time this was missed has received counseling/disciplinary action.

187d - Follow Prescriber's Orders (continued)

In-servicing for all med techs, which included this regulation, was conducted on 2/6/24. Additional one on one trainings were conducted the week of 2/12/24. Training record attached.

Home's eMAR system is reviewed daily by on-site, notifications any errors are flagged. The HWD or designee will review on a weekly basis as well.

Each med tech on staff will complete no less than two observed medication passes to ensure compliance with this regulation. A record of these observations will be kept and the home will complete these by 3/31/24.

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

Not Implemented (██████████ 5/8/24)

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

Facility Information

Name: *THE SHERIDAN AT BETHEL PARK* License #: *44948* License Expiration: *06/01/2024*
Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA 15234*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *KJ BETHEL PARK LLC*
Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA, 15234*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *12/13/2019* Issued By: *Dept L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *160* Waking Staff: *120*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint, Provisional, Incident* Exit Conference Date: *03/08/2024*

Inspection Dates and Department Representative

02/22/2024 - On-Site: [REDACTED]
02/23/2024 - On-Site: [REDACTED]
03/08/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* Residents Served: *118*

Secured Dementia Care Unit

In Home: *Yes* Area: *MC1 and MC2* Capacity: *40* Residents Served: *35*

Hospice

Current Residents: *24*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *117*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *42* Have Physical Disability: *0*

Inspections / Reviews

02/22/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/08/2024*

04/08/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *05/01/2024*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/15/2024*

04/15/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *05/01/2024*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *05/01/2024*

05/08/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: *05/01/2024*
Reviewer: [REDACTED] Follow-Up Type: *Exception*

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 2/22/24 at 10:31 a.m., a copy of 55 Pa. Code Chapter 2600 and the licensing inspection summary, dated 5/3/23, were not posted in a conspicuous and public place in the home.

REPEAT VIOLATION: 6/27/2023 et al.

Plan of Correction

Accept [REDACTED] 04/15/2024)

Home has an inspection binder available in a conspicuous and accessible area to all residents, families and visitors.

At the time of inspection, summary results from the 5/3/23 inspection were identified as missing but home put in place while inspector was on site.

New Personal Care Home Administrator (PCHA) is in place and has audited the inspection binder to confirm all other inspections are included for review. First audit was done on 2/23/24. Auditing was completed weekly in March and will continue to be weekly throughout April 2023. Audit consists of checking for past inspection summaries in the binder and confirming that the public summary is available to view.

PCHA/Executive Director is response for the audit and will be responsible to updating the inspection binder each time there is a new inspection survey.

Licensee's Proposed Overall Completion Date: 04/30/2024

Not Implemented [REDACTED] - 5/8/24)

Licensee's Proposed Date for POC Implementation

16b - Incident Policies

2. Requirements

2600.

16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home's written policy on reportable incidents does not address the prevention, reporting, notification, investigation, and management of reportable incidents and conditions.

Plan of Correction

Accept [REDACTED] 04/15/2024)

The home presented the managing company's abuse policy at the time of inspection. Since the inspection the home has requested an updated policy that includes all items listed in this regulation including PA specific reporting and notification. That has been included and is attached for review.

All home's staff will be in-serviced on regulation 260016(b) and the home's updated policy throughout the month of April and will be completed no later than 4/30/24. Training will be completed by the Health & Wellness Director, Assistance Health & Wellness Director and the Executive Director.

Licensee's Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Date for POC Implementation

Implemented [REDACTED] 05/08/2024)

17 - Record Confidentiality

3. 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 2/22/24 at 10:34 a.m., the resident privacy coding document, containing the names of 12 residents, including resident #1 and resident #2, was attached to the licensing inspection summary, dated 3/22/23, in the survey binder at the front desk.

On 2/22/24 at 12:26 p.m., the emergency preparedness manual on the entry table in the lobby contained the complete resident list including dates of birth, room number, mobility status, and mental health status.

REPEAT VIOLATION: 6/27/2023 et al.

Plan of Correction

Accept [REDACTED] 04/15/2024)

During the 2/22/24 inspection confidential information was found located in both the inspection survey binder and in the emergency preparedness binder. Those items were removed at the time of inspection.

Both the inspection binder and the emergency preparedness binder are accessible to residents, families, visitors and staff therefore confidential information should not be included. All staff persons will be educated on regulation 2600.17 by the Executive Director, this training will be completed by 4/30/24 and will be kept in a training binder in the administrator's office.

New PCHA started in February 2024 and has audited both binders to confirm no other confidential information is included in these binders.

Moving forward, PCHA will check placement and contents of binders weekly to ensure compliance. This started 4/8/24.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)

26a - Quality Management Plan

4. Requirements

2600.

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

Description of Violation

The home had not implemented its quality management plan as it had not conducted a quality management review in the past year, from 2022 until 3/5/24.

Plan of Correction

Accept [REDACTED] 04/15/2024)

While PC home's company has a policy in place to complete a Quality Assurance (quality management plan) review on a quarterly basis, there was no record of these meetings occurring.

26a - Quality Management Plan (continued)

New PCHA started in February 2024. A quality management meeting was held on 3/5/24 with the on-site leadership team which included reviewing regulation 2600.26a and the company's policy. Meeting minutes attached for review.

For the next six months, PCHA will conduct a monthly Quality Management Plan review with the leadership team and will move to quarterly thereafter.

For monitoring, the PCHA will submit copies of the QMP review to the Regional Director of Operations starting in April 2024, and each month it is completed after. RDO will review to ensure meeting is being held and that all required topics are being covered in accordance with 2600.26a.

Licensee's Proposed Overall Completion Date: 04/10/2024

Licensee's Proposed Date for POC Implementation

Implemented [REDACTED] 05/08/2024)

81a - Accommodation**5. Requirements**

2600.

81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

The home's policy on Assistive Device for Bed Standard, dated 9/13/13 and revised 3/3/23, does not address the periodic assessment of the installation and maintenance of the device and that it remains appropriate for the resident. Resident #3 uses a halo bed enabler.

REPEAT VIOLATION: 11/6/2023

Plan of Correction

Accept [REDACTED] 04/15/2024)

Home's policy has been updated to include the periodic assessment of equipment necessary to meet the health and safety needs of residents with disabilities.

Home's staff responsible for completing the assessment will be in-serviced on the updated policy and this regulation by 4/12/24.

An assessment of all resident equipment will be completed by 4/26/24 to ensure compliance. Assessment will be completed by the HWD or AHWD.

PCHA/Executive Director will monitor monthly to ensure the assessment is being completed on any resident with equipment in place. PCHA will start monitoring step on 4/29/24.

Licensee's Proposed Overall Completion Date: 04/29/2024

Licensee's Proposed Date for POC Implementation

Implemented [REDACTED] 05/08/2024)

81b - Resident Personal Equipment**6. Requirements**

2600.

81b - Resident Personal Equipment (continued)

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

On 3/8/24, the halo bed enabler on resident #3's bed measured 8.5" by 5.5" at the widest point and was loosely covered with a pillow case, moved approximately 6" back and forth, and was not attached firmly to the bed frame, posing an entrapment hazard.

Plan of Correction**Accept** [REDACTED] - 04/15/2024)

Cover has been secured to Resident #3's halo so that is no longer loose fitting. Enabler was also firmly attached to the bed frame by the Maintenance Director on 3/9/24.

All care, housekeeping and maintenance staff will receive in-servicing on this regulation by 4/12/24.

For the next two months, weekly rounds will be done in which all bed enablers will be checked for compliance with this regulation. These rounds will begin the week of 4/8/24.

Licensee's Proposed Overall Completion Date: 04/12/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)**85a - Sanitary Conditions****7. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/22/24 at 11:00 a.m., there was an unlabeled round hairbrush and two electric razors in the unlocked and accessible first drawer in the MC2 activities room.

On 2/22/24 at 11:23 a.m., the bottom of the freezer in the MC1 kitchenette was coated with several inches of ice, with a box of ice cream sandwiches and ice cream cones frozen into it.

On 2/22/24 at 11:28 a.m., there was an unlabeled comb and two hairbrushes in the unlocked and accessible first drawer in the MC1 activities room.

Plan of Correction**Accept** [REDACTED] 04/15/2024)

Personal hairbrush and electric razor located in an accessible drawer in the activities room were immediately removed by the Health & Wellness Director.

New Memory Care Director started in March. MCD does daily rounds within the SDCU to ensure no personal items are left in accessible areas but instead are in locked apartment cabinets and that items are labeled. All care staff have been in-serviced on this requirement.

Freezer with ice buildup and items frozen in the ice was immediately placed out of order until it was defrosted and cleaned.

A daily checklist has been put in place for both MC freezer/fridge units. Checklist is to be completed daily starting 4/11/24 to ensure sanitary conditions are met in accordance with regulation 2600.85a. For the next month the MCD, manager on duty or PCHA will also review the daily checklist daily to ensure staff are completing properly.

85a - Sanitary Conditions (continued)

Education will be provided to all staff by their supervisor or the Executive Director on regulation 2600.65i. This will be completed by 4/30/24 and documentation will be kept in a training binder in the administrator's office.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)

85d - Trash Receptacles

8. 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

On 2/22/24 at 10:16 a.m., there was a full, uncovered trash can in the main kitchen.

Plan of Correction

Accept [REDACTED] - 04/15/2024)

Full trash can with no lid was immediately removed from the kitchen on 2/22/24. A new trash can with a lid was ordered and put in place.

All kitchen staff will be in-serviced on the requirement of keeping the trash receptacles covered, this training to be conducted by the Director of Culinary Services. This will be completed by all kitchen staff no later than 4/19/24. A sign was posted on the trash receptacle as well.

Director of Culinary Services or his designee will review this daily for the next month starting on 4/9/24.

Licensee's Proposed Overall Completion Date: 04/19/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)

95 - Furniture and Equipment

9. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 3/8/24 at 11:45 a.m., the bathroom sink in resident #3's room made a loud, grinding sound when using the cold water and trickled slowly when using the hot water.

Plan of Correction

Accept [REDACTED] 04/15/2024)

During the time of inspection, a work order was submitted, and the sink was repaired by the on-site Maintenance Director so that it no longer made a noise and water flowed normally. The work was reported and completed on 3/8/24. There had been no prior work orders or reports of issues with the sink prior to inspection.

Moving forward, on-site housekeepers will check resident bathroom sinks during their regularly scheduled weekly housekeeping service to ensure there are no concerns. Housekeepers will monitor for water to flow normally in the sink. If there are any needed repairs a work order will be submitted, and the Maintenance Director will respond timely.

All resident sinks will be inspected by the maintenance staff for any similar issues no later than 4/12/24.

95 - Furniture and Equipment (continued)

All staff persons will receive education from their supervisor or the Executive Director on regulation 2600.95 no later than 4/30/24. Documentation of training will be kept in a training binder in the administrator's office.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)

101j7 - Lighting/Operable Lamp

10. 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

On 3/8/24, resident #4 did not have access to a source of light that can be turned on/off at bedside. The nearest source of light was approximately seven feet from the head of the resident's bed.

Plan of Correction

Accept ([REDACTED] 04/15/2024)

A light source has been moved to resident's bedside on 4/5/24 by a member of the care staff, picture attached.

Starting the week of 4/8/24 and for the next 30 days after, weekly rounds will be conducted in all resident units to ensure that this regulation is being met in each apartment. This monitoring will be conducted by lead med techs or a designee. In the event a resident room is without a light source at their bedside the home will put one in place.

PCHA will also review weekly checklists and will spot check rooms to confirm audit compliance.

All staff persons will receive education from their supervisor or the Executive Director on regulation 2600.65i no later than 4/30/24. Documentation of training will be kept in a training binder in the administrator's office.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] 5/8/24)

103d - Storing Food Off Floor

11. Requirements

2600.

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

Description of Violation

On 2/22/24 at 10:48 a.m., there were (two) 5 lb. boxes of powdered instant nonfat dry milk stored on the floor in the second-floor storage closet near the club room.

Plan of Correction

Accept [REDACTED] 04/15/2024)

The box of powdered milk that was sitting on the floor was immediately removed by the Maintenance Director from the storage area on 2/22/24.

Staff who have access to this area have been in-serviced on proper storage which includes keeping any food items, even those in containers, off the floor. In-servicing was completed by the Executive Director and Director of Culinary Services. In-servicing started on 4/5/24 and it will be completed by 4/30/24.

103d - Storing Food Off Floor (continued)

Additionally, signage was posted in this storage area as a reminder on how to store any food items.

A member of the facility management teams will check this area weekly for the next month to ensure items are stored properly. Monitoring began the week of 4/8/24.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Implemented [REDACTED] **05/08/2024)**

103f - Refrigerator/Freezer Temps**12. Requirements**

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 2/22/24 at 11:23 a.m., the temperature in the MC1 kitchenette's freezer measured 2 degrees Fahrenheit.

Plan of Correction

Accept [REDACTED] **04/15/2024)**

The MC1 freezer was reading at 2 degrees and not the required 0 degrees or below. This freezer was emptied, place out of order and serviced immediately.

Daily temp log has been implemented and is monitored weekly by the Memory Care Director or designee. Any concerns with the temperature are immediately reported to the community maintenance director.

All staff persons will receive education from their supervisor or the Executive Director on regulation 2600.103f no later than 4/30/24. Documentation of training will be kept in a training binder in the administrator's office.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Implemented [REDACTED] **05/08/2024)**

103i - Outdated Food**13. Requirements**

2600.

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

Description of Violation

On 2/22/24 at 10:20 a.m., the following unlabeled, undated foods were in the walk-in freezer in the main kitchen:

- 1 plastic container of fish filets*
- 1 plastic container of several pounds of chicken wings*
- chicken breasts wrapped loosely in cellophane*

On 2/22/24 at 11:23 a.m., there was an undated styrofoam container of chocolate and strawberry ice cream in the freezer in the MC1 kitchenette.

Plan of Correction

Accept [REDACTED] **04/15/2024)**

Undated/unlabeled items in the walk-in freezer and MC1 kitchenette were immediately discarded.

103i - Outdated Food (continued)

All MC staff and kitchen staff will be educated on regulation 2600.103i no later than 4/30/24. Training will be conducted by the Director of Culinary Services, Memory Care Director or Executive Director and documentation of training will be kept in the administrator's office.

Starting the week of 4/8/24 and for the next 30 days after, facility will do daily checks in MC kitchenettes and walk-in freezer to ensure compliance with this regulation.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Implemented (████) 05/08/2024)

107c - Food/Water 3 Day Supply**14. Requirements**

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 3/8/24, the home served 118 residents, requiring 354 gallons of emergency drinking water. Staff indicated that each resident room had either 1 gallon of emergency water per resident, including resident #4 and #5's shared room and resident #6's room, or 2 gallons of emergency water per resident, including resident #1's room, resident #7's room, and resident #8's room. The home had less than 2 gallons of emergency water per resident, and their contract with Dean's Water Service, dated 8/9/22, indicates that delivery would take at least one day and their obligation to the home would be limited.

Plan of Correction

Accept (████) 04/15/2024)

While facility does have emergency water in place and an emergency water contract in place with a vendor, the volume needed to cover the 3-day supply was not met.

The week of 4/8/24 facility will order additional gallons of water. Facility's Maintenance Director will be placing a three-day supply in each resident unit for each resident that is labeled as 'emergency water' and lists an expiration date, picture attached. This will be completed by 4/16/24.

Starting 4/17/24 during weekly housekeeping visits in resident units, the housekeepers will confirm that these are in place for each resident. In the event any are missing maintenance will be notified and water will be replaced in order to maintain the 3-day supply. Maintenance will have extra water available in the event they need replacements.

Licensee's Proposed Overall Completion Date: 04/17/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (████) - 5/8/24)

141b1 - Annual Medical Evaluation**15. Requirements**

2600.

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

Description of Violation

Resident #3's most recent medical evaluation was completed on █████/23; however, the resident's previous medical evaluation was completed on 10/21/21.

141b1 - Annual Medical Evaluation (continued)

Resident #4's most recent medical evaluation was completed on [REDACTED]/24; however, the resident's previous medical evaluation was completed on 8/1/22. The resident's current medical evaluation is missing the resident's height and weight. These areas of the form are blank.

Resident #9's most recent medical evaluation, dated [REDACTED]/23, indicates immunizations are current; however, the Td/Tdap date, influenza date, and other immunization fields are blank.

REPEAT VIOLATION: 11/6/2023; 6/27/2023 et al.; 3/22/2023 et al.

Plan of Correction

Directed ([REDACTED] - 04/15/2024)

Resident #4's DME will be updated to include height and weight by 4/12/24.

Resident #9's immunization field will be updated by 4/12/24.

Audit of all resident DMEs has started and will be completed by 4/12/24 by the Health & Wellness Director to ensure they have been completely annually.

DMEs are to be completed and reviewed by the Health & Wellness Director, Assistant Health & Wellness Director and reviewed by the PCHA starting 4/8/24. All have reviewed this regulation, training attached.

Proposed Overall Completion Date: 04/12/2024

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator or designee shall audit all resident medical evaluations for timeliness and completeness. Documentation of audits shall be kept. [REDACTED] 1/15/24

Directed Completion Date: 04/16/2024

Licensee's Proposed Date for POC Implementation

Not Implemented ([REDACTED] - 5/8/24)

183d - Prescription Current**16. Requirements**

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 2/23/24, the following discontinued medications for resident #8 were in the medication cart:

- duloxetine, discontinued 12/14/23
- ondansetron HCL 4mg tab, discontinued 12/20/23
- acetaminophen 325mg tab, discontinued 12/27/23
- metformin 600mg, discontinued 12/27/23

On 2/23/24, resident #10's guaifenesin and dextromethorphan hydrobromide syrup 100mg/10mg/5m was in the medication cart; however, it was discontinued on 12/7/23.

REPEAT VIOLATION: 6/27/2023 et al.; 5/3/2023 et al.

Plan of Correction

Accepted ([REDACTED] 04/15/2024)

All discontinued medications have been removed from the medication cart by the AHWD the week of 4/8/24.

In-servicing for all med techs will be completed by 4/12/24 on the review of this regulation.

183d - Prescription Current (continued)

Weekly med cart audits started the week of 3/25/24 on all med carts and will be completed by a nurse on a weekly basis for the next two months. There after it will be done by a med tech on a weekly basis.

Next pharmacy cart audit is scheduled on June 12, 2024. This will be completed by the home's contracted pharmacy provider.

Licensee's Proposed Overall Completion Date: 04/12/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] /8/24)

183e - Storing Medications

17. 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

On 2/23/24, resident #7's Lantus insulin pen was not labeled with the date opened.

Resident #10's brimonidine tartrate ophthalmic solution 0.2% was opened on 7/20/23. According to the manufacturer's instructions, the medication expires 4 weeks after opening; however, it was still present in the home.

Resident #10's dorzolamide ophthalmic drops was opened on 7/20/23. According to the manufacturer's instructions, the medication expires 28 days after opening; however, it was still present in the home.

REPEAT VIOLATION: 6/27/2023 et al.; 3/22/2023 et al.

Plan of Correction

Accept [REDACTED] - 04/15/2024)

Expired medications have been removed from the medication cart. AHWD will review carts again the week of 4/8/24 to ensure there are no other discontinued medications on the cart.

In-servicing for all med techs will be completed by 4/12/24 on the review of this regulation. This will be conducted by the HWD and AHWD, documentation will be kept in a training binder in the administrator's office.

Weekly med cart audits started the week of 3/25/24 on all med carts and will be completed by a nurse on a weekly basis for the next two months. Thereafter it will be done by a med tech on a weekly basis.

Licensee's Proposed Overall Completion Date: 04/12/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [REDACTED] - 5/8/24)

184a - Resident's Meds Labeled

18. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
4. The prescribed dosage and instructions for administration.

184a - Resident's Meds Labeled (*continued*)

5. The name and title of the prescriber.

Description of Violation

Resident #7 is prescribed oxycodone HCL 5mg-Take .5 tab by mouth as needed every 6 hours; however, the medication pharmacy label indicates-5mg tablet, take half tab 2.5mg by mouth every evening; and every 6 hours as needed.

Resident #10 is prescribed loperamide HCL 2mg caps-Take 2mg by mouth every 6 hours as needed; however, the medication pharmacy label indicates-Take 2mg 3 times daily as needed.

Resident #10 is prescribed brimonidine tartrate ophthalmic solution 0.2%-Instill 2 drops to each affected eye 2 times daily; however, the medication pharmacy label indicates-Instill 1 drop in both eyes twice daily.

Resident #10 is prescribed Humalog insulin-Inject 3 units subcutaneously with meals and per sliding scale 4 times a day: Blood sugar 70-140 = 0; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340=5 units; 341-400=6 units. However, the medication pharmacy label indicates: Inject 3 units subcutaneously 3 times daily. Give after patient eats at least half meal rotate sites. Sliding scale 4 times before meals and bedtime: Blood sugar 70-140 = 1 unit; 141-180=2 units; 181-220=3 units; 221-260=4 units; 261-300=5 units; 301-340=6 units; 341-400 (blank)

Resident #11 is prescribed lorazepam-Take 0.5ml syringe by mouth 3 times daily; however, the medication pharmacy label indicates-One syringe by mouth under the tongue every 4 hours as needed.

Resident #11 is prescribed morphine 0.5ml syringe-Take 0.5ml under the tongue every 2 hours as needed; however, the medication pharmacy label indicates-Give 5mg (0.25ml) by mouth every hour as needed.

REPEAT VIOLATION: 3/22/2023 et al.

Plan of Correction

Accept [REDACTED] 04/15/2024)

AHWD contacted each resident PCP for clarification on orders and if necessary contacted pharmacy for changes.

Resident #7's order for oxycodone was discontinued and a new order was put in place by her physician. A copy of that order is attached, label matches.

Resident #10- Loperamide order correct, pharmacy corrected the label and resent. Confirmation attached.

Resident #10's brimonidine tartrate ophthalmic eye drop order changed, label was correct. Order attached for review.

Community nurse reviewed Resident #10's Humalog injection order with the PCP. Physician plans to review this in person with the home and after assessing the resident in person on 4/16/24. Order and/or label will be updated as needed.

Resident #11- PCP confirmed Lorazepam order was correct, pharmacy label corrected and attached.

Resident #11 order updated to sublingual, label matches.

On site nursing staff are reviewing all orders and confirming all medications have the appropriate labels that

184a - Resident's Meds Labeled (continued)

include all required information.

In-servicing for all med techs will be completed by 4/12/24 on the review of this regulation.

Weekly med cart audits started the week of 3/25/24 on all med carts and will be completed by a nurse on a bi-weekly basis for the next two months. Thereafter it will be done by a med tech on a weekly basis. These audits will include reviewing pharmacy labels for required information.

Licensee's Proposed Overall Completion Date: 04/16/2024
 Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] - 5/8/24)

185a - Implement Storage Procedures

19. Requirements

2600.

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

Description of Violation

On 2/23/24, resident #7's glucometer was not calibrated to the correct date and time.

On the following dates and times, resident #7's blood sugar readings on her glucometer did not coincide the blood sugar readings recorded on her blood glucose/insulin administration report:

Date	Time	Glucometer Reading	Administration Report
2/23	11:12am	190	198
2/21	8:18pm	none	125
2/21	11:25am	173	172
2/20	7:57pm	235	239

Resident #7 is prescribed zofran 4mg-Take 1 tablet by mouth as needed every 8 hours; however, on 2/23/24, the medication was not available in the home.

On 2/23/24, resident #10's glucometer was not calibrated to the correct time.

On the following dates and times, resident #10's blood sugar readings on her glucometer did not match the blood sugar readings recorded on her blood glucose/insulin administration report:

Date	Time	Glucometer Reading	Administration Report
2/23	11:46am	197	196
2/23	7:31am	184	185
2/22	approx 8:22pm	180	no reading

REPEAT VIOLATION: 6/27/2023 et al.; 3/22/2023 et al.

Plan of Correction

Accept [redacted] - 04/15/2024)

Resident #7's Zofan was not available in the home at the time of inspection, this order has since been discontinued by hospice. Staff failed to contact the pharmacy for refill timely. Med Techs received training on 2600.185a on 4/10/24 and 4/12/24.

185a - Implement Storage Procedures (continued)

Resident #7 and #10's glucometer dates and times was corrected and is now accurate.

Monitoring- All glucometer dates and times will be reviewed on a weekly basis by the Heath & Wellness Director and/or Assistant Health & Wellness Director during weekly audits for the next two months. During their weekly audits they will confirm glucometers are stored properly,

All med techs will receive additional training on using the glucometers and recording accurate information by 4/12/24.

Licensee's Proposed Overall Completion Date: 04/15/2024

Not Implemented (█ - 5/8/24)

Licensee's Proposed Date for POC Implementation

187a - Medication Record**20. Requirements**

2600.

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #7 is prescribed Novolog 100 units/ml 4 times daily per sliding scale: 70-139 = 0 units; 140-179=1 unit; 180-219 = 2 units; 220-259= 3 units; 260-299= 4 units; 300-339= 5 units; 340-379= 6 units; 380 and above = administer 8 units and call MD. However, the resident's February 2024 medication administration record (MAR) indicates-for blood glucose reading greater than 380 = administer 6 units and call MD.

Resident #7 is prescribed Lidocaine 4%patch-Apply to left shoulder in AM, off bedtime; however, the resident's February 2024 MAR indicates-Apply 2 times per day everyday at 9:00 a.m. and 8:00 p.m.

Resident #8 is prescribed tylenol 500mg-Take 2 by mouth every 6 hours as needed; however, the resident's February 2024 MAR indicates-oral tablet 325mg; 500mg oral tablet – 2 tablets by mouth 3 times a day.

Resident #8 is prescribed mirtazapine 7.5mg-Take 1 tablet by mouth at bedtime; however, the resident's February 2024 MAR indicates-7.5 mg tablet 1 tablet by mouth one time daily at 7pm; but indicates 7pm and 9am administration times.

187a - Medication Record (continued)

Resident #10 is prescribed Humalog insulin-Inject per sliding scale 4 times a day: Blood sugar 70-140 = 0; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340=5 units; 341-400=6 units.

However, █████ February 2024 MAR indicates:

<u>Date</u>	<u>Time</u>	<u>glucometer reading</u>	<u>units recorded</u>	<u>correct units</u>
2/20	11:32am	157	0	1
2/20	4:39pm	276	0	4
2/20	8:46pm	144	0	1
2/21	7:17am	150	0	1
2/21	11:00am	162	0	1
2/21	8:23pm	196	0	2
2/23	7:00am	185	5	2

Resident #11 is prescribed morphine 0.5ml syringe-Take 0.5 ml under the tongue every 2 hours as needed; however, the resident's February MAR indicates-0.5 ml syringe, Take 1 syringe every 2 hours and take 0.25 mg oral syringe one every hour as needed.

REPEAT VIOLATION: 6/27/2023 et al.; 3/22/2023 et al.

Plan of Correction

Directed █████ - 04/15/2024)

In-servicing for all med techs will be completed by 4/12/24 on the review of this regulation.

The Health & Wellness Director (RN) and Assistant Health & Wellness Director (LPN) will be reviewing and managing all orders moving forward to ensure orders and MAR have matching information. In addition, HWD and AHWD are doing full medication reviews for all residents to ensure medication records have all required information and that it is being followed on the home's MAR. This will be completed by 4/30/24.

Proposed Overall Completion Date: 04/30/2024

DIRECTED Within one day of the receipt of the accepted plan of correction: The administrator or designated staff person shall complete a weekly audit of all resident MARs to ensure compliance with Regulation 2600.187(a).

Documentation of audits shall be kept. █████ 4/15/24

Directed Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Not Implemented █████ - 5/8/24)

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

On 2/10/24, resident #8 was prescribed mirtazapine 7.5mg-Take 1 tablet by mouth at bedtime; however, the medication was also administered at 9:00 a.m. daily from 2/14/23 through 2/23/23.

Resident #10 is prescribed carvidilol 3.125mg-Take 1 tablet twice a day with breakfast and dinner; however, the resident is administered 6.25mg tablets. In addition, █████ administration time is 3:00 p.m.; however, dinner is served

187d - Follow Prescriber's Orders (continued)

from 4:45 p.m.-6:45 p.m.

Resident #10 is prescribed latanoprost ophthalmic solution 0.005%-Instill 1 drop in both eyes daily; however, the medication was not administered on 2/22/23 and 2/23/23 because it was not available in the home.

Resident #10 is prescribed Humalog insulin-Inject per sliding scale 4 times a day: Blood sugar 70-140 = 0; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340=5 units; 341-400=6 units. However, on 2/22/24, the resident's blood sugar was only measured 3 times.

REPEAT VIOLATION: 6/27/2023 et al.; 5/3/2023 et al.; 3/22/2023 et al.

Plan of Correction

Directed [REDACTED] - 04/15/2024)

In-servicing for all med techs on 2600.187d as well as the policy and procedure for ensuring prescribed medications are available in the home for administration will be completed by 4/12/24 by the HWD and AHWD. Any additional training needs identified on these topics will be addressed by the HWD/AHWD/ED by 4/30/24. Documentation will be kept in the administrator's office.

Home's Health & Wellness Director and Assistant Health & Wellness Director, who are both nurses, will schedule medication pass observations with all med techs in the month of April. In the event a Med Tech requires additional training and/or supervision, nurses will schedule immediately.

Initial med cart audits started on 3/25/24 and were completed by the AHWD by 4/13/24. Once the initial audit is fully completed bi-weekly audits will start, these will be completed by the AHWD and the HWD for the next two months and monthly thereafter. A review of these audits will be done with the administrator. Documentation on these audits will be kept in the administrator's office. Ongoing weekly audits will be conducted by designated med techs on a weekly basis.

Med Techs have been in-serviced on medication communication such as reporting missed meds, medication errors and medications that are unavailable. Med Techs are to immediately alert the HWD or AHWD, the resident's designated person and the physician. This was reviewed at the April staff meetings on 4/10 and 4/12 but will be reviewed again one on one during med tech observations. In the event a state incident reportable is needed, the administrator or HWD will complete and submit. Any state incident reports are added to the resident's chart and a copy is placed in an incident binder that is stored in the administrator's office.

Proposed Overall Completion Date: 04/30/2024

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall notify the residents and the resident's designated person of the medication errors for each resident. Documentation of notification shall be kept. [REDACTED] 4/15/24

Within one calendar day of receipt of the accepted plan of correction: The administrator shall notify the prescriber's of the medication errors for each resident. The home shall follow the direction of the prescriber related to the medication errors. Documentation of notifications shall be kept. [REDACTED] 4/15/24

Within one calendar day of receipt of the accepted plan of correction: The administrator shall file an incident report

187d - Follow Prescriber's Orders (continued)

for the medication errors. Documentation shall be kept. [REDACTED] 4/15/24

Within one calendar day of receipt of the accepted plan of correction: The administrator shall make each medication error part of the resident's permanent records. [REDACTED] 4/15/24

Directed Completion Date: 04/30/2024

Not Implemented [REDACTED] - 5/8/24)

Licensee's Proposed Date for POC Implementation

190b - Insulin Injections

22. 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 person A's most recent diabetes patient education program was completed on 1/22/2023; however, [REDACTED] administered insulin injections to multiple residents on various dates and times, including the following:

- novolog insulin to resident #7 at 8:00 p.m. on 2/2/2024, 2/5/2024, 2/6/2024, 2/11/2024, 2/14/2024, 2/15/2024, 2/16/2024 AND 2/18/2024.
- humalog insulin to resident #10 on 2/11/23 at 7:00 a.m.

Plan of Correction

Accept [REDACTED] 04/15/2024)

Staff person A successfully completed the Department approved diabetic training and test on 4/3/24 with a certified instructor.

Community has developed an internal tracker to monitor med tech training and ensure this requirement is being met and that it's done timely. Med techs who are not in compliance with this training will not be permitted to administer insulin injections.

At this time all med techs have the appropriate training on file and it has been completed timely. Both the PCHA and the Health & Wellness Director will review the training documents and the employee training tracker on a monthly basis starting on 4/8/24.

Licensee's Proposed Overall Completion Date: 04/12/2024

Licensee's Proposed Date for POC Implementation

Implemented [REDACTED] 05/08/2024)

191 - Resident Right to Refuse

23. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #12, admitted [REDACTED] 23, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

191 - Resident Right to Refuse (continued)

REPEAT VIOLATION: 6/27/2023 et al.

Plan of Correction

Accept (████) 04/15/2024)

Resident #12 has been educated on the right to refuse medication, attached. This right acknowledgement was overlooked for resident #12 on a previous audit. This right has been reviewed with Resident #12 and █████ has signed acknowledging the review.

All resident leases now have this right listed for residents to review and sign, attached. This lease document, including resident rights, is reviewed upon admission by the resident.

Business Office Manager and PCHA will audit all resident files by 4/30/24 to ensure compliance for all residents.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (████) - 5/8/24)

225a - Assessment 15 Days

24. 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 #8 was admitted on █████/23; however, the resident's initial assessment is undated, therefore, timeliness is unable to be determined.

Resident #12 was admitted on █████/2023; however, the resident's assessment was not completed until 8/3/2023 and does not indicate the resident's diagnoses of ambulatory dysfunction, seropositive rheumatoid arthritis, chronic ischemic right PCA stroke, hypertension, stage 3 chronic kidney disease, obstructive sleep apnea, and anemia as indicated on the resident's most recent medical evaluation, dated 6/15/23.

REPEAT VIOLATION: 11/6/2023; 6/27/2023 et al.

Plan of Correction

Accept (████) 04/15/2024)

Resident #12's missing diagnoses will be listed on the assessment, this will be completed by the HWD by 4/12/24.

Home has a new PCHA, Health & Wellness Director (RN) and Assistant Health & Wellness Director (LPN) in place, all have received training on this regulation.

HWD, AHWD and PCHA will audit all resident assessments starting the week of 4/8/24 to confirm that the correct information is being captured upon admission and that the assessment is available on the resident chart.

Starting the week of 4/8/24, for future admissions HWD or AHWD will complete the initial assessment and PCHA will review upon admission to confirm all information has been captured correctly.

Licensee's Proposed Overall Completion Date: 04/12/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (████) 5/8/24)

225c - Additional Assessment

25. 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.

Description of Violation

Resident #3's most recent assessment is dated [REDACTED]/23; however, [REDACTED] previous assessment is dated 11/12/21. Also, the resident's most recent assessment does not indicate the diagnoses of monoplegia of upper limb, facial weakness, TIA, altered mental status, muscle wasting and atrophy, paralytic gait, hypertension, hyperlipidemia, osteoarthritis, atherosclerotic heart disease, DMII, history of pulmonary embolism as indicated on the resident's most recent medical evaluation, dated [REDACTED]0/23.

Resident #7's most recent assessment, dated [REDACTED]24, does not indicate the diagnoses of subarachnoid hemorrhage, essential hypertension, afib, DMII, coronary artery disease, and hyperlipidemia as indicated on the resident's most recent medical evaluation, dated 12/6/23. In addition, there is no assessment of the resident's social and recreational needs.

Resident #13's most recent assessment is dated 8/10/23; however, there was no previous assessment in the home. Therefore, timeliness of the document is not able to be determined. In addition, the assessment does not indicate the diagnoses of anxiety, down syndrome, mental retardation, and hypothyroidism as indicated on the resident's most recent medical evaluation, dated 7/20/23. Also, there is no assessment of dental needs, dietary needs, and recreational needs.

REPEAT VIOLATION: 6/27/2023 et al.; 3/22/2023 et al.

Plan of Correction

Accept ([REDACTED] - 04/15/2024)

Resident #3, #7 and #13's assessments will be updated by the HWD or AHWD by 4/30/24.

Home's staff responsible for completing the annual assessment have been in-serviced on this regulation, attached.

An audit of all resident assessments will be completed by 4/30/24 to ensure all residents have a complete and accurate assessment done annually or upon change of condition.. The HWD and AHWD will be completing this audit.

Starting the week of 4/8/24, for future assessments, one approved assessor will complete the assessment and a second approved assessor will review to ensure all areas have been completed successfully and timely.

For future assessments, one person will complete the assessment and a second person will review to ensure all areas have been completed successfully and that the correct diagnoses information has been pulled from the most recent medical evaluation.

Home's electronic charting system tracks due dates for assessments which assists the home in tracking annual due dates on assessments. The home's nurse managers and PCHA have access to review this and will be reviewing daily to adhere to this regulation.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Not Implemented ([REDACTED] 5/8/24)

227a - Support Plan 30 Days

26. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #12 was admitted on [REDACTED] 2023; however, the resident's initial support plan was completed on 11/11/23. Also, the support plan indicates a diagnosis of lymphedema; however, there is no plan to meet this medical need. This area of the form is blank.

REPEAT VIOLATION: 6/27/2023 et al.

Plan of Correction

Directed [REDACTED] - 04/15/2024)

Resident #12's support plan will be updated by 4/30/24 to include the missing diagnoses and the plan to support this medical need.

The home's staff responsible for completing the annual assessment have been in-serviced on this regulation, attached.

An audit of all resident records will be completed by 4/30/24 to ensure all residents have a complete and accurate support plan. The HWD and AHWD will be completing this audit.

Starting the week of 4/8/24, for future assessments, one approved assessor will complete the assessment and a second approved assessor will review to ensure all areas have been completed successfully and that the correct diagnoses information has been pulled from the most recent medical evaluation.

Proposed Overall Completion Date: 04/30/2024

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall have all newly completed support plans reviewed for accuracy and completeness [REDACTED] 4/15/24

Directed Completion Date: 04/30/2024

Not Implemented [REDACTED] 5/8/24)

Licensee's Proposed Date for POC Implementation

227c - Support Plan Revision**27. 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 #3's most recent support plan is undated, therefore timeliness of the document cannot be determined. Also, it does not indicate the resident's use of a wheelchair and walker for ambulation, and the need, specific type of device, and plan to prevent danger of the resident's halo bed enabler.

Resident #9's most recent assessment was completed on [REDACTED] 8/23; however, [REDACTED] most recent support plan was completed on 11/2/23, which is not within 30 days of the assessment.

Resident #13's most recent assessment was completed on [REDACTED] 23; however, [REDACTED] most recent support plan was

227c - Support Plan Revision (continued)

completed on 11/12/23, which is not within 30 days of the assessment.

REPEAT VIOLATION: 6/27/2023 et al.

Plan of Correction

Accept (█) - 04/15/2024)

Resident #3's support plan will be updated to indicate the resident's use of a wheelchair and walker for ambulation, as well as the need, specific type of device and plan to prevent danger of the resident's halo bed enabler.

The HWD, AHWD and ED will audit all current resident files by 4/30/24 to ensure all residents have a complete and accurate support plan completed and in the resident record.

The home's staff responsible for updating the support plan within 30-days of admission have been in-serviced on this regulation, attached.

Starting the week of 4/8/24, for future 30-day assessments/support plan revisions, one approved assessor will complete the assessment and a second approved assessor will review to ensure all areas have been completed successfully and that the correct diagnosis information has been pulled from the most recent medical evaluation. The home's EHR system also tracks due dates of assessment.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (█) - 5/8/24)

227g -Support Plan Signatures

28. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3's support plan, which is undated, is not signed by the assessor.

Resident #7's support plan, dated █ 24, is not signed by the assessor.

REPEAT VIOLATION: 11/6/2023; 6/27/2023 et al.; 5/3/2023 et al.

Plan of Correction

Accept (█) 04/08/2024)

Resident #3's support plan will be updated, dated and signed by the assessor.

Resident #7's support plan will be updated and signed by the assessor.

Previous assessor for both assessments is no longer employed by the home therefore new assessments had to be completed to obtain a new assessor signature.

HWD, AHWD and ED will audit all current support plans by 4/16/24 to ensure appropriate signatures have been obtained.

Licensee's Proposed Overall Completion Date: 04/16/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (█) - 5/8/24)

227h - Support Plan Refuse Sign

29. Requirements

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #3's support plan, which is undated, is not signed by the resident and does not indicate if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Resident #7's support plan, dated [REDACTED]/24, is not signed by the resident and does not indicate if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction

Accept [REDACTED] - 04/15/2024)

Resident #3 and #7s support plans will be signed by the residents by 4/12/24

HWD, AHWD and PCHA will audit all support plans by 4/30/23 to ensure resident signatures have been obtained or there is an indication of whether they could not participate, declined to participate or were unable to sign.

Home's approved assessors have been in-serviced on this regulation. Starting 4/8/24 all support plans will be reviewed by a second approved assessor to ensure all information has been obtained in order to comply with this regulation.

Licensee's Proposed Overall Completion Date: 04/30/2024
Licensee's Proposed Date for POC Implementation

Not Implemented ([REDACTED] - 5/8/24)

231b - Medical Evaluation

30. Requirements

2600.

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

Description of Violation

Resident #11 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED] 3; however, the resident's medical evaluation, dated [REDACTED] 23, does not indicate the need for the resident to be served in an SDCU.

REPEAT VIOLATION: 6/27/2023 et al.; 3/22/2023 et al.

Plan of Correction

Accept [REDACTED] - 04/15/2024)

Resident #11's current medical evaluation lists the need for the SDCU.

HWD, AHWD and PCHA will audit all SDCU medical evaluations by 4/16/23 to ensure that the need for a resident to be serviced in a SDCU is indicated on the medical evaluation.

Home's approved assessors have been in-serviced on this regulation.

231b - Medical Evaluation (continued)

Starting 4/8/24 all medical evaluations for the SDCU will be reviewed by a second approved assessor to ensure the need for a SDCU has been documented on the evaluation within the appropriate time frame. Executive Director will also review the medical evaluation for every new resident to the SDCU starting on 4/8/24.

Licensee's Proposed Overall Completion Date: 04/08/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (█ - 5/8/24)

231e - No Objection Statement**31. Requirements**

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #10 was admitted to the SDCU on █ 23; however, the home has no documentation that the resident and the resident's designated person have not objected to the admission.

REPEAT VIOLATION: 6/27/2023 et al.

Plan of Correction

Accept (█ 04/15/2024)

Home contract/lease agreement has been updated to include the 'no objection' statement for all Secure Dementia Care Unit admissions, attached.

An addendum has been created to review this regulation with all SDCU residents and their designated person. This addendum will be reviewed and signed by all by 4/30/24.

The Business Office Manager will audit SDCU resident records by 4/12/24 to ensure that regulation was reviewed upon admission or that an addendum was included to review it.

As new residents move in the Business Office Manager or Executive Director will review new SDCU resident files to confirm this was reviewed and signed during admission. this will be ongoing for all new SDCU residents.

Licensee's Proposed Overall Completion Date: 04/12/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (█ - 5/8/24)

234a - Admission Support Plan**32. Requirements**

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #11 was admitted to the Secure Dementia Care Unit (SDCU) on █ 23; however, the resident's initial support plan is undated, therefore, its timeliness of the document is unable to be determined. In addition, the resident receives hospice services; however, the resident's support plan does not indicate the care and services or frequency of services that are being provided by hospice. Also, the resident uses a hooyer lift; however, this is not indicated on the resident's support plan.

REPEAT VIOLATION: 11/6/2023; 6/27/2023 et al.; 5/3/2023 et al.; 3/22/2023 et al.

234a - Admission Support Plan (continued)

Plan of Correction

Accept [redacted] **04/15/2024)**

Resident #11's support plan will be updated to indicate the care and services or frequency of service that are being provided by hospice, as well as the use of a hooyer lift. This will be updated by the HWD by 4/19/24.

All SDCU support plans will be reviewed by the ED, HWD, AHWD or the MCD by 4/19/24. Audit will look for compliance of regulation 2600.234a.

Home's approved assessors have been in-serviced on this regulation by 4/9/24. Moving forward all support plans will be reviewed by a second approved assessor to ensure all information has been obtained in order to comply with this regulation.

Upon admission a second approved assessor must review the initial support plan within the first 72 hours to ensure compliance. The executive director will also review all new resident admission paperwork moving forward.

Licensee's Proposed Overall Completion Date: 04/19/2024

Not Implemented [redacted] **- 5/8/24)**

Licensee's Proposed Date for POC Implementation

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

Facility Information

Name: *THE SHERIDAN AT BETHEL PARK* License #: *44948* License Expiration: *06/01/2024*
Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA 15234*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *KJ BETHEL PARK LLC*
Address: *2000 COOL SPRINGS DRIVE, PITTSBURGH, PA, 15234*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *12/13/2019* Issued By: *Dept L&I*

Staffing Hours

Resident Support Staff: Total Daily Staff: *161* Waking Staff: *121*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Incident* Exit Conference Date: *04/05/2024*

Inspection Dates and Department Representative

03/19/2024 - On-Site: [REDACTED]
03/20/2024 - Off-Site: [REDACTED]
04/02/2024 - Off-Site: [REDACTED]
04/05/2024 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *147* Residents Served: *119*

Secured Dementia Care Unit

In Home: *Yes* Area: *MC1 and MC2* Capacity: *40* Residents Served: *35*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *118*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *42* Have Physical Disability: *0*

Inspections / Reviews

03/19/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/20/2024*

04/16/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *05/06/2024*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/23/2024*

04/30/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *05/06/2024*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *05/06/2024*

05/08/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: *05/06/2024*
Reviewer: [REDACTED] Follow-Up Type: *Exception*

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 3/13/24 at approximately 2:00 p.m., staff person A and staff person B were sitting at a table in the SDCU dining room with resident #1. Resident #1 was rubbing staff person B's hand for comfort when staff person A suddenly smacked the resident's hand away very hard. Resident #1 became defensive and put [redacted] fists up as if to fight staff person A. Staff person A then roughly grabbed the resident below [redacted] wrists to stop [redacted] and took resident #1 to [redacted] room, where staff person B could hear the resident yelling. Staff person A continued to work [redacted] shift. AT approximately 6:00 p.m., resident #1 was seen touching [redacted] ear, and [redacted] told staff person B that [redacted] ear hurt. Staff person B observed blood in that area and called over staff person C who saw that the ear lobe was detached. Resident #1 told staff person C that the [redacted] next door did it. When staff person A was brought to the SDCU, resident #1 pointed to [redacted] with no prompting, and said - [redacted] the one who pulled on my ear. Upon further inspection, resident #1 also had a skin tear on [redacted] arm. Police were called to the home and indicated they are pressing charges against staff person A. Resident #1 was taken to the hospital and treated for a laceration on [redacted] ear/right face and a bruise on [redacted] right arm and left hand. The initial incident occurred on 3/13/24 at approximately 2:00 p.m. However, the incident was not reported to the Area Office on Aging until 3/13/24 at approximately 7:30 p.m.

Plan of Correction**Directed [redacted] - 04/30/2024)**

Resident injury identified and resident reported suspected abuse at approximately 6p. Staff immediately responded to resident to care for injuries. Within minutes of that on site staff alerted the Executive Director and the accused staff member was suspended pending investigation. On site staff focused on resident care and removal of the suspended employee. On site staff alerted resident's hospice provider and the resident's POA. The Executive Director collected information on what had occurred and called AAA to first complete the initial verbal report, this was done at 7:30p. Documentation of that verbal call is included in the AAA Mandatory Abuse Report that was faxed the following morning and within the reporting guidelines. Executive Director also called the Bethel Park police and completed incident reporting for BHSL the evening of the incident. All mandatory reporting steps were followed in the appropriate timeframe. Community's initial focus was to ensure that the Resident's injuries were addressed, and that Staff person A was removed from the property.

Staff person B never reported the interaction that occurred earlier in the day on 3/13/24. Had this interaction been reported, on site management would have alerted AAA, area police and BHSL earlier as well as suspended staff person A at that time pending investigation.

At the conclusion of the investigation staff person A was terminated.

Staff person B received counseling on reporting any and all concerns or suspected abuse immediately. Staff person B did receive abuse training prior to this incident.

Immediately after this incident the Memory Care Director started in-servicing all Memory Care staff on abuse reporting. This regulation was reviewed again during care staff meetings on 4/10/24 and 4/12/24. All community staff are doing additional abuse training and testing to be completed by 4/19/24.

Community will continue abuse training with all staff on a monthly basis for the next three months. Monitoring-

15a - Resident Abuse Report (continued)

administrator will review monthly training at the conclusion of a month to ensure all staff have participated. This review will be done by the 5th of each month. Training will include a skills check to confirm staff have understood the information presented to them. Administrator or designee will review skills checks to determine if any additional trainings are needed. All training documentation will be stored in the administrator's office.

Proposed Overall Completion Date: 04/30/2024

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all allegations of abuse to ensure all allegations of abuse are reported in accordance with Regulation 2600.15(a) 4/30/24.

Directed Completion Date: 05/01/2024

Licensee's Proposed Date for POC Implementation

Implemented 05/08/2024

15b - Supervisor Plan**2. Requirements**

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 3/12/24 at approximately 7:00 p.m., resident #2 was asleep in the common area of the SDCU and was woken up by staff person A because [REDACTED] wanted to move [REDACTED] to [REDACTED] room. [REDACTED] was in a very groggy state upon waking and was stumbling when [REDACTED] attempted to walk. Staff person A put resident #2 in a wheelchair that was being stored in the room, although the resident does not normally use one. Staff person A did not put the footrests on the chair and thought resident #2 could keep [REDACTED] feet up during the entire trip back to [REDACTED] room. However, staff person A was pushing the wheelchair fast enough that when resident #2 lowered [REDACTED] feet, [REDACTED] was propelled out of the chair and fell forward, striking [REDACTED] face on the floor. A private caregiver for another resident was nearby and seconds later observed the resident lying on [REDACTED] side on the floor, covered in a huge amount of blood, with a large lump already forming on [REDACTED] forehead, crying and moaning and saying-My arm, my arm. EMS arrived at 7:07 p.m. and took the resident to the hospital, where [REDACTED] was admitted and diagnosed with fractures of [REDACTED] right humerus and bilateral nasal bones and a frontal scalp soft tissue hematoma. However, staff person A was not suspended until [REDACTED] 24 between 6:30 p.m. and 7:00 p.m.

On 3/13/24 at approximately 2:00 p.m., staff person A and staff person B were sitting at a table in the SDCU dining room with resident #1. Resident #1 was rubbing staff person B's hand for comfort when staff person A suddenly smacked the resident's hand away very hard. Resident #1 became defensive and put [REDACTED] fists up as if to fight staff person A. Staff person A then roughly grabbed the resident below [REDACTED] wrists to stop [REDACTED] and took resident #1 to [REDACTED] room, where staff person B could hear the resident yelling. Staff person A continued to work [REDACTED] shift. AT approximately 6:00 p.m., resident #1 was seen touching his ear, and [REDACTED] told staff person B that [REDACTED] ear hurt. Staff person B observed blood in that area and called over staff person C who saw that the ear lobe was detached. Resident #1 told staff person C that the [REDACTED] next door did it. When staff person A was brought to the SDCU, resident #1 pointed to [REDACTED] with no prompting, and said - [REDACTED] the one who pulled on my ear. Upon further inspection, resident #1 also had a skin tear on [REDACTED] arm. Police were called to the home and indicated they are pressing charges against staff person A. Resident #1 was taken to the hospital and treated for a laceration on [REDACTED] right face and a bruise on [REDACTED] right arm and left hand.

15b - Supervisor Plan (continued)

The initial incident occurred on 3/13/24 at approximately 2:00 p.m. However, staff person A was not suspended until [REDACTED] 4 between 6:30 p.m. and 7:00 p.m.

Plan of Correction**Directed [REDACTED] 04/30/2024)**

On 3/12/24 Staff person A reported seeing resident #2 looking unsteady. In order to get this resident to [REDACTED] apartment safely [REDACTED] was transported to a wheelchair so that [REDACTED] could be transported to [REDACTED] apartment to rest. The staff member neglected to add legs onto the wheelchair. As a result, the resident dropped [REDACTED] legs in transit causing [REDACTED] to catch [REDACTED] feet on the ground and fall forward out of the chair. This occurred in a hallway area and Staff member A immediately alerted the med tech on duty. Both employees alerted an on-site manager. During the time of the report there was no indication of abuse, instead failing to add on the wheelchair legs before transit was poor judgment. Had any form of abuse been suspected, community staff would have reported to AAA, police and BHSL as well as suspended the employee pending investigation.

Staff person B never reported the interaction that occurred earlier in the day on 3/13/24. Had this interaction been reported, on site management would have alerted AAA, area police and BHSL earlier as well as suspended staff person A at that time pending investigation.

At the conclusion of the investigation staff person A was terminated.

Staff person B received counseling on reporting any and all concerns or suspected abuse immediately. Staff person B did receive abuse training prior to this incident.

Mandatory abuse training was reviewed during care staff meetings on 4/10/24 and 4/12/24. All community staff are doing additional abuse training and testing to be completed by 4/19/24. Community will continue abuse training with all staff on a monthly basis for the next three months.

Monitoring- administrator will review monthly training at the conclusion of each month to ensure all staff have participated. This will be completed by the 5th of each month. Training will include a skills check to confirm staff have understood the information presented to them. Administrator or designee will review skills checks to determine if any additional trainings are needed. Any training documentation will be stored in the administrator's office.

All care staff will receive training on proper use of wheelchairs no later than 4/26/24, this will include the use of wheelchairs legs while in transit.

Proposed Overall Completion Date: 04/26/2024

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all allegations of abuse to ensure any staff person alleged of abuse is immediately suspended or placed on a plan of supervision approved by the department and the Area Agency on Aging. [REDACTED] 4/30/24.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: 05/01/2024

Licensee's Proposed Date for POC Implementation

Implemented [REDACTED] 05/08/2024)

42b - Abuse

3. Requirements

2600.

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

Description of Violation

On 3/12/24 at approximately 7:00 p.m., resident #2 was asleep in the common area of the SDCU and was woken up by staff person A because ■ wanted to move ■ to ■ room. ■ was in a very groggy state upon waking and was stumbling when ■ attempted to walk. Staff person A put resident #2 in a wheelchair that was being stored in the room, although the resident does not normally use one. Staff person A did not put the footrests on the chair and thought resident #2 could keep ■ feet up during the entire trip back to ■ room. However, staff person A was pushing the wheelchair fast enough that when resident #2 lowered ■ feet, ■ was propelled out of the chair and fell forward, striking ■ face on the floor. A private caregiver for another resident was nearby and seconds later observed the resident lying on ■ side on the floor, covered in a huge amount of blood, with a large lump already forming on ■ forehead, crying and moaning and saying-My arm, my arm. EMS arrived at 7:07 p.m. and took the resident to the hospital, where ■ was admitted and diagnosed with fractures of ■ right humerus and bilateral nasal bones and a frontal scalp soft tissue hematoma.

On 3/13/24 at approximately 2:00 p.m., staff person A and staff person B were sitting at a table in the SDCU dining room with resident #1. Resident #1 was rubbing staff person B's hand for comfort when staff person A suddenly smacked the resident's hand away very hard. Resident #1 became defensive and put ■ fists up as if to fight staff person A. Staff person A then roughly grabbed the resident below ■ wrists to stop ■ and took resident #1 to ■ room, where staff person B could hear the resident yelling. Staff person A continued to work ■ shift. AT approximately 6:00 p.m., resident #1 was seen touching ■ ear, and ■ told staff person B that ■ ear hurt. Staff person B observed blood in that area and called over staff person C who saw that the ear lobe was detached. Resident #1 told staff person C that the ■ next door did it. When staff person A was brought to the SDCU, resident #1 pointed to ■ with no prompting, and said - ■ the one who pulled on my ear. Upon further inspection, resident #1 also had a skin tear on ■ arm. Police were called to the home and indicated they are pressing charges against staff person A. Resident #1 was taken to the hospital and treated for a laceration on ■ ear/right face and a bruise on ■ right arm and left hand.

Plan of Correction**Directed ■ 04/30/2024)**

Resident injury identified and resident reported suspected abuse at approximately 6p. Staff immediately responded to resident to care for injuries. Within minutes of that on site staff alerted the Executive Director and the accused staff member was suspended pending investigation. On site staff focused on resident care and removal of the suspended employee. On site staff alerted resident's hospice provider and the resident's POA. The Executive Director collected information on what had occurred and called AAA to first complete the initial verbal report, this was done at 7:30p. Documentation of that verbal call is included in the AAA Mandatory Abuse Report that was faxed the following morning and within the reporting guidelines. Executive Director also called the Bethel Park police and completed incident reporting to BHSL the evening of the incident. All mandatory reporting steps were followed in the appropriate timeframe. Community's initial focus was to ensure that the Resident's injuries were addressed, and that Staff person A was removed from the property.

Staff person B never reported the interaction that occurred earlier in the day on 3/13/24. Had this interaction been reported, on site management would have alerted AAA, area police and BHSL earlier as well as suspended staff person A at that time pending investigation.

42b - Abuse (continued)

At the conclusion of the investigation staff person A was terminated.

Staff person B received counseling on reporting any and all concerns or suspected abuse immediately. Staff person B did receive abuse training prior to this incident.

Immediately after this incident the Memory Care Director started in-servicing all Memory Care staff on abuse reporting. This regulation was reviewed again during care staff meetings on 4/10/24 and 4/12/24. All community staff are doing additional abuse training and testing to be completed by 4/19/24. Community will continue abuse training with all staff on a monthly basis for the next three months. All community staff receive training on mandatory abuse reporting as well as types of abuse.

Administrator will conduct three private interviews with residents on a weekly basis for the next three months. Template interview questionnaire is attached, records will be maintained in the administrator's office. Interviews will start the week of 4/22/24

Proposed Overall Completion Date: 04/22/2024

DIRECTED

Within five calendar days of receipt of the accepted plan of correction: The administrator shall conduct private interviews of at least three residents a week for three months and three residents a month by the administrator to ensure compliance with Regulation 2600.42(b). Documentation of interviews shall be kept. ■ 4/30/24

Directed Completion Date: 05/05/2024

Not Implemented ■ - 5/8/24)

Licensee's Proposed Date for POC Implementation

65i - Training Record**4. Requirements**

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training for topics required in accordance with regulation 2600.65b for direct care staff person A, hired ■ 23, does not include the date of the training.

Plan of Correction

Directed ■ - 04/30/2024)

Staff person A's initial training was completed upon hire, but the training was not dated. Other trainings completed the same day were dated.

Community's Business Office Manager oversees staff onboarding and has been trained on regulation 42b. BOM will audit all staff files by 4/30/24 to confirm all required information has been captured appropriately on staff records.

Monitoring- BOM will review all training documents at the end of the first week of hire to ensure all required training information has been recorded properly in accordance with 2600.42b. The Executive Director will also review as a second set of eyes to confirm all documents is completed and on the employee record.

65i - Training Record (continued)

Proposed Overall Completion Date: 04/30/2024

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall conduct a review of all staff training records as part of the quality management review process to ensure compliance with Regulation 2600.65(i) [REDACTED] 4/30/24.

Directed Completion Date: 05/01/2024

Not Implemented [REDACTED] - 5/8/24)

Licensee's Proposed Date for POC Implementation

141b1 - Annual Medical Evaluation**5. Requirements**

2600.

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

Description of Violation

Resident #2's most recent medical evaluation, dated [REDACTED]/23, indicates multiple changes to the original information; however, it does not indicate that a registered nurse or licensed practical nurse contacted the person who performed the evaluation, received permission from that person to correct the information, and documented the date, time, and person spoken to next to the correction, in the following areas:

- special health or dietary needs – indicates a change from 'can safely use or avoid poisonous materials' to a need for 'secured dementia care.'
- body positioning/movement - indicates a change from 'none' to 'listed below: shuffles.'
- health status - indicates a change from 'good' to 'fair.'
- cognitive functioning - indicates a change from 'good' to 'poor.'
- mobility - indicates a change from 'limited' to 'moderate'

In addition, the immunization section indicates immunizations are current; however, the Td/Tdap, influenza date, and other immunizations sections of the form are blank.

REPEAT VIOLATION: 11/6/2023; 6/27/2023 et al. ; 3/22/23 et al.

Plan of Correction

Directed ([REDACTED] - 04/30/2024)

Residents are scheduled to receive annual medical evaluations annually that coincide with annual service plan reviews. The community's electronic charting tracks due dates for this annual requirement. The HWD, AHWD and ED have access to monitor this tracking. Starting 4/16/24, on a daily basis the HWD and/or AHWD will review the electronic tracker and share upcoming due dates for annual assessments/medical evaluations at the daily manager meeting so that proper arrangements can be made to update the annual evaluations timely. HWD and AHWD will be responsible for completing these timely. As completed the electronic tracker will be updated. ED will monitor daily for compliance.

According to the community's records, the last Annual Medical Evaluation/DME was completed on 9/21/23 and was signed by the resident's PCP. This DME is attached for review. This may have been misfiled at the time of review.

Community's MCD, AHWD, HWD and ED will audit all resident medical evaluations to confirm that they are filed appropriately, that they are timely, and that all information is recorded correctly. This audit was completed on 4/16/24.

141b1 - Annual Medical Evaluation (continued)

Proposed Overall Completion Date: 04/16/2024

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator or designee shall audit all newly completed medical evaluation documentation to ensure accuracy and completeness. ■■■ 4/30/24.

Directed Completion Date: 05/01/2024

Not Implemented ■■■ - 5/8/24)

Licensee's Proposed Date for POC Implementation

187d - Follow Prescriber's Orders

6. Requirements

2600.

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

Description of Violation

On Friday, 3/8/24, staff person D did not administer multiple medications to various residents in the SDCU, including the following:

- resident #1, prescribed:
 - humalog insulin 100u/ml-Inject 5 units subcutaneously twice daily before breakfast and lunch; however, it was not administered before breakfast.
 - citalopram 20mg-Take 1 tablet once daily; however, the medication was not administered.
 - levothyroxine 125mcg-Take 1 tablet once daily; however, the medication was not administered.
 - lidocaine 4% patch-Apply 1 patch to left hip once a day; 12 hours on/12 hours off; however, the patch was not administered.
 - lisinopril 40mg-Take 1 tablet once daily; however, the medication was not administered.
 - metoprolol 50mg-Take 1 tablet once daily; however, the medication was not administered.
 - Toujeo Solostar 300u/ml-Inject 16 units once daily; however, the medication was not administered.
- resident #3, prescribed:
 - acetaminophen 325mg-Take 2 tablets once daily; however, the medication was not administered.
 - seroquel 50mg-Take 1 tablet 3 times daily; however, it was only administered at 5:00 p.m. and 9:00 p.m.
 - sertraline 100mg-Take 1 tablet once daily; however, the medication was not administered.
- resident #4 is prescribed:
 - amlodipine 5mg-Take 1 tablet once daily; however, the medication was not administered.
 - aspirin 81mg-Take 1 tablet once daily; however, the medication was not administered.
 - atenolol 25mg-Take ½ tab twice daily on Friday, Saturday, and Sunday; however, the medication was only administered one time, at 8:00 p.m.
 - hydrochlorothiazide 12.5mg-Take 1 tablet once daily; however, the medication was not administered.
 - sertraline 50mg-Take 1 tablet once daily; however, the medication was not administered.
 - acetaminophen 500mg-Take 2 caps twice daily; however, the medication was administered only at 5:00 p.m.

REPEAT VIOLATION: 6/27/2023 et al.; 5/3/2023 et al. ; 3/22/23 et al.

Plan of Correction

Accept ■■■ 04/30/2024)

On 3/8/24 a med tech on Memory Care called off for their shift. The second med tech (Med Tech #1) on memory care was instructed to take both carts and continue with the med pass, one med tech is permitted to manage both

187d - Follow Prescriber's Orders (continued)

carts. The med tech to resident ratio is well within range for one med tech. Med Tech #1 argued about this assignment and evening reported [REDACTED] needed to leave. A lead med tech on site who was working on administrative tasks asked Med Tech #1 repeatedly to finish the morning pass for both carts before leaving [REDACTED] shift, at which point the lead med tech would count [REDACTED] out and manage the carts. Med Tech #1 agreed to this but it wasn't until [REDACTED] left that the lead med tech realized that Med Tech #1 did not following instructions, instead [REDACTED] only finished the morning medication pass for one floor not both as instructed.

Community staff reported these missed medications in an incident report to BHSL, contacted each resident's PCP's and each residents' POAs on the day this occurred. A copy of the incident report is in all resident charts/permanent records. Incident report attached.

Med Tech #1 was suspended pending investigation and ultimately terminated on [REDACTED]/24.

Med Techs received training on 2600.187d on 4/10/24 and 4/12/24.

Community's electronic charting and eMAR system allows nurse managers to review missed medications, or medications that are not marked as given in the appropriate time frame. The HWD and AHWD monitor this daily. Any errors are reported to resident PCPs, nurses also report to the community's Executive Director in the event any state incident report is required.

Licensee's Proposed Overall Completion Date: 04/16/2024

Not Implemented [REDACTED] - 5/8/24)

Licensee's Proposed Date for POC Implementation

234d - Support Plan Revision**7. Requirements**

2600.

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

Description of Violation

Resident #2's most recent assessment, dated [REDACTED]/23, indicates the resident requires assistance with ambulation; however, the resident's most recent support plan, dated [REDACTED] does not indicate the plan, frequency, and responsible person to meet this need. These areas of the form are blank.

REPEAT VIOLATION: 11/6/2023

Plan of Correction

Accept [REDACTED] - 04/30/2024)

Resident #2 has moved out of the community, home's staff are unable to make revisions and add the plan, frequency, or responsible person for ambulation needs.

The home's staff will audit all support plans to ensure there is a plan, frequency and designated person to meet the need of any residents with ambulation needs. This initial audit started on 4/16/24. Any necessary revisions will be made thereafter.

Moving forward a second approved assessor will review any new support plans to ensure these requirements are captured in the support plan. Approved assessors received training on 2600.234a and the requirement for a second reviewed on 4/15/24.

234d - Support Plan Revision (continued)

All approved assessors will be in-serviced on this regulatory requirement by 4/30/24.

Licensee's Proposed Overall Completion Date: 04/30/2024

Not Implemented [REDACTED] - 5/8/24)

Licensee's Proposed Date for POC Implementation