pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **THE VILLAGES OF HARMAR, LLC**
LEGAL ENTITY

To operate **THE VILLAGES OF HARMAR**
NAME OF FACILITY OR AGENCY

Located at **715 FREEPORT ROAD, CHESWICK, PA 15024**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Assisted Living-Special Care**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **133** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Special Care Unit - 55 Pa.Code §§ 2800.231-239 - Capacity 23**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 2, 2024** until **February 2, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454562**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: **AUGUST 2 , 202**4

[redacted], President
The Villages of Harmar, LLC
[redacted]

RE: The Villages of Harmar
715 Freeport Road
Cheswick, Pennsylvania 15024
License/COC #: 454562

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on February 27, 2024, February 28, 2024, March 8, 2024, March 25, 2024, March 26, 2024, April 23, 2024, and April 24, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), 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, the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision 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). Your SECOND PROVISIONAL license is enclosed and is valid from August 2, 2024 to February 2, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (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 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
17	III	71	$3	$213	15 calendar days from mailing date of this letter
184(a)	II	71	$5	$355	5 calendar days from mailing date of this letter
185(a)	II	71	$5	$355	5 calendar days from mailing date of this letter
187(b)	II	71	$5	$355	5 calendar days from mailing date of this letter
16(c)	II	71	$5	$355	5 calendar days from mailing date of this letter
141(b)(1)	II	71	$5	$355	5 calendar days from mailing date of this letter
183(d)	II	71	$5	$355	5 calendar days from mailing date of this letter
187(d)	II	71	$5	$355	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 issue a PROVISIONAL 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. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

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.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *THE VILLAGES OF HARMAR* **License #**: *45456* **License Expiration**: *06/21/2024*

Address: *715 FREEPORT ROAD, CHESWICK, PA 15024*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *THE VILLAGES OF HARMAR, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/12/2024* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *95* **Waking Staff**: *71*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date**: *03/08/2024*

Inspection Dates and Department Representative

02/27/2024 - On-Site: [redacted]
02/28/2024 - On-Site:
03/08/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *133* **Residents Served**: *72*

Special Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *23* **Residents Served**: *18*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *23* **Have Physical Disability**: *0*

Inspections / Reviews

02/27/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/31/2024*

04/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/12/2024*

04/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2024*

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

06/07/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

17 Record confidentiality

1. Requirements

2800.

17. Confidentiality of Records - 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 2/27/24 at 10:23 AM, medical information and records for numerous residents were unlocked, unattended and accessible at the 2nd floor nurses station, which included a green binder containing blood pressures, pulse rates, respiratory counts and weights for residents residing on the 1st, 2nd and 3rd floors.

On 2/27/24 at 11:39 AM, medical information and records for numerous residents were unlocked, unattended and accessible at the 1st floor nurses station, which included numerous resident assignment sheets and resident care information, a communication book containing care notes for numerous residents and resident #1's Bridges Hospice record.

On 2/27/24 at 12:01 PM, medical information and records for numerous residents were unlocked, unattended and accessible at the 2nd floor North nurses station, which included a 2 North communication book containing care notes for numerous residents.

On 2/27/24 at 12:15 PM, medical information and records for numerous residents were unlocked, unattended and accessible at the 3rd floor north nurses station, which included a folder containing July 2023 Medication Administration Records (MAR's) for 29 residents, as well as a binder containing shower sheets for numerous residents.

REPEAT VIOLATION: 9/26/2023, et. al.; 8/28/2023, et. al.

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

Upon identification of the protected information, the records were removed immediately the day of inspection by the Administrator. On 2/28/2024, all nursing stations were cleaned and protective information was removed. Education was provided on 3/26/2024, by the Administrator or designee to staff with access to protected information, this education's documentation will be kept in accordance to the PA 2800 regulations. Each nurses station is equipped with locking drawers and those drawers will be utilized for any PHI needing to be stored at the nurses station. These drawers will be utilized effective 4/19/2024 Moving forward the Administrator or designee will conduct daily rounding when in the facility, for all nursing stations and facility postings to ensure PHI is not accessible. This daily rounding will be completed once per shift when able, but no less than daylight and evening shifts. Daily rounding began on 4/8/2024. This audit will take place indefinitely as part of the facility's daily operations. Audit results will be discussed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

17 Record confidentiality *(continued)*

18 Other laws, regs, ordins.

2. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

According to the Care Facility Carbon Monoxide Alarms Standards Act, enacted in 9/2016, battery-operated carbon monoxide detectors must be labeled with the date of battery installation. On 2/27/24, the battery-operated carbon monoxide detector located outside the residence's boiler room did not include the date of battery installation.

Plan of Correction ***Accept (- 04/16/2024)***

Once the inspection concluded, the carbon monoxide act was reviewed as part of the plan of correction development. The Administrator is currently working with the maintenance department to ensure all battery operated CO detectors have had their batteries changed within the last year. The administrator provided education on 3/26/24 to staff regarding the requirements of the CO act. This education will be kept in accordance to the PA 2800 regulations. All documentation of when the batteries were changed was provided to DHS upon inspection, however, the Administrator or designee will ensure that tape, some other label, or writing on the battery is added to each battery operated CO detector with the most recent date of a battery change. This information has been added to these detectors as of 4/2/2024. Moving forward the monthly audits required by the maintenance department will continue and be conducted by the maintenance department/designee. This documentation will be kept in the maintenance office. Audit results will be discussed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Implemented (- 06/07/2024)

22a1 Medical Eval - time frames

3. Requirements

2800.
22.a. Documentation. The following admission documents shall be completed for each resident:
1. Medical evaluation completed within 60 days prior to admission on a form specified by the Department. The medical evaluation may be completed within 15 days after admission if one of the following conditions applies
i. The resident is being admitted directly to the residence from an acute care hospital.
ii. The resident is being admitted to escape from an abusive situation
iii. The resident has no alternative living arrangement.

Description of Violation

Resident #2 was admitted to the residence on ; however, resident #2's medical evaluation was not completed until

Plan of Correction ***Directed (- 04/16/2024)***

Prior to the inspection the facility had conducted and completed audits of all ADME's in December of 2023. This

22a1 Medical Eval - time frames (continued)

resident was identified previous as someone without an ADME, the Administrator and designee worked in the month of January to ensure all residents had a current ADME. The Administrator or designee conducted education of the regulatory requirements in the RCG to direct care staff regarding this violation on 3/26/2024. This education will be kept in accordance to the PA 2800 regulations. All nursing staff responsible for ADMEs will be educated by 4/23/24. This education will also be kept in accordance to the PA 2800 regulations. As of 4/4/2024 all residents have a new, current, 2024 ADME and these ADME's are being audited monthly by the administrator or nursing team to ensure that a tracking and monitoring system is in place. A baseline audit of all resident ADME's will be conducted prior to 5/1/2024 by the administrator or designee. After the baseline audit is completed, new admission records will be audited within 72 hours of admission by the administrator/designee. The facility is utilizing a spreadsheet created during the audits in 2023 that is being used as a monitoring tool to ensure timely ADME's are completed. Audit results will be discussed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

DIRECTED: By 4/25/24: The administrator shall develop and implement a new admission checklist to ensure a medical evaluation is completed in its entirety for all new admissions, which includes all items specified in 2800.141(a), within 60 days prior to admission in accordance with 2800.22(a). Copies of the completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be education on the new checklist by 4/25/24. Documentation of the education shall be kept in accordance with 2800.65L. [redacted] 4/16/24

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Implemented ([redacted] - 06/07/2024)

25a Resident - residence contract

4. Requirements

2800.

25.a. Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #2 was admitted to the residence on [redacted]; however, resident #2's resident-residence contract was not signed by the administrator/designee and resident #2 until [redacted]

REPEAT VIOLATION: 9/26/2023, et. al.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Prior to the inspection the facility had conducted and completed audits of all contracts in December of 2023. This resident was identified previous as someone without a signed contract, the Administrator and designee worked in the month of January to ensure all residents had a signed contract. The Administrator or designee conducted education to staff regarding this violation on 3/26/2024 education based on the most recent RCG. Education regarding

25a Resident - residence contract (continued)

contract signatures to be provided to all management no later than 4/24/24 by Saber Regional team. This education will be kept in accordance to the PA 2800 regulations. As of 4/4/2024, all residents have a new, signed contract. Moving forward the administrator or designee will audit 10 contracts per month beginning 4/8/2024. As part of the residence's monitoring step, the administrator/designee will review new admission contracts within the first 24 hours of admission to ensure they are complete and signed timely. (DIRECTED: The administrator/designee review of all new admission resident-residence contracts shall begin on 4/22/24. [redacted] 4/16/24). Once all current contracts are audited and verified as current, the administrator or designee will review new admission contracts at the facility's quality management meetings. The next meeting is scheduled for the last week of April, and will include all new admission contracts from March and April 2024. Audit results/new admission contracts will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

DIRECTED: By 4/25/24: The administrator shall develop and implement a new admission checklist to ensure a resident-residence contract is completed and signed by all applicable parties prior to admission or within 24 hours after admission in accordance with 2800.25(a) and 2800.25(b). Copies of the completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be education on the new checklist by 4/25/24. Documentation of the education shall be kept in accordance with 2800.65L. [redacted] 4/16/24

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *04/25/2024*

Implemented ([redacted] - 06/07/2024)

25b Contract signatures and renewal

5. Requirements

2800.

25b . 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. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

Resident #6's resident-residence contract, dated [redacted], is not signed by resident #6.

REPEAT VIOLATION: 8/28/2023, et .al.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Prior to the inspection the facility had conducted and completed audits of all contracts in December of 2023. This resident was identified previous as someone without a signed contract, the Administrator and designee worked in the month of January to ensure all residents had a signed contract. The Administrator or designee conducted education to staff regarding this violation on 3/26/2024 education based on the most recent RCG. Education regarding contract signatures to be provided to all management no later than 4/24/24 by Saber Regional team. This education will be kept in accordance to the PA 2800 regulations. In this specific situation, the resident was unable to sign due to their medical diagnosis. The contract was signed by the resident's POA, however no documentation was provided that the resident was unable to sign. As of 4/4/2024 this resident's contract does indicate that the resident is unable to sign due to their diagnoses. Moving forward the Administrator/designee will review all contract signatures of residents who are unable to sign for themselves, due to their medical diagnoses no later than 4/19/2024. Any issues found

25b Contract signatures and renewal (continued)

through this review will be corrected immediately (no later than 4/19/2024). The administrator/designee will conduct the same audits of 10 contracts per month which began 4/8/24. As part of the residence's monitoring step, the administrator/designee will review new admission contracts within the first 24 hours of admission to ensure they are complete and signed timely. (DIRECTED: The administrator/designee review of all new admission resident-residence contracts shall begin on 4/22/24. [redacted] 4/16/24). Once all current contracts are audited and verified as current, the administrator or designee will review new admission contracts at the facility's quality management meetings. The next meeting is scheduled for the last week of April, and will include all new admission contracts from March and April 2024. Audit results/new admission contracts will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

DIRECTED: By 4/25/24: The administrator shall develop and implement a new admission checklist to ensure a resident-residence contract is completed and signed by all applicable parties prior to admission or within 24 hours after admission in accordance with 2800.25(a) and 2800.25(b). Copies of the completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be education on the new checklist by 4/25/24. Documentation of the education shall be kept in accordance with 2800.65L. [redacted] 4/16/24

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *04/25/2024*

Not Implemented ([redacted] - 06/07/2024)

69 Dementia training

6. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Direct care staff person A, hired on [redacted], only received 2.5 hours of dementia-specific training.

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

Since hire, staff member A has received 9.75 hours of dementia related training with an additional 6.25 hours assigned through the remainder of the year. In late 2023, as part of previous POC, the facility had identified initial training as an area of focus due to the high volume of citations that are typically found surrounding that in other facilities. Due to this the facility has since implemented that initial training is to be completed prior to working on the floor, including dementia related trainings, this implementation happened approximately 1/20/2024. All staff are expected to complete initial training, the temple DCS training, as well as RELIAS learning. The facility is utilizing a new hire orientation checklist to ensure that these trainings are complete prior to a staff member working on the floor and providing care. Moving forward the administrator/designee will review staff RELIAS training transcripts to ensure these have been completed, this review will be completed no later than 4/19/24. RELIAS learning is the program the facility utilizes for the new hire staff training. The Administrator or designee conducted education to staff regarding this violation on 3/26/2024. This education will be kept in accordance to the PA 2800 regulations. This education was directed at direct care staff regarding what the process is for any new hire's initial training, and

69 Dementia training (continued)

the training was based off of the requirements of the 2800 RCG. Staff responsible for monitoring RELIAS transcripts will be educated on the expectations and facility procedures no later than 4/23/2024. The administrator/designee will audit new hire trainings within 30 days of their hire to ensure this regulation is met. These audits will be indefinite as part of the facility's day to day operations and believed best practice and will begin 5/1/2024. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

Licensee's Proposed Overall Completion Date: *05/01/2024*

Implemented ([redacted] - 06/07/2024)

81a Disability accommodation

7. Requirements

2800.
81.a. The residence 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 residence.

Description of Violation

On 2/27/24 at approximately 11:00 AM, the bilateral enablers at the top of resident #7's bed move approximately 2" from side to side. Both enablers are attached to resident #7's bedframe with cable ties and are not securely attached to the bed frame. Also, the opening of the lower portion of both enablers measured approximately 6" X 14", which poses an entrapment hazard.

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

As of 4/4/2024 both enablers attached to this resident's bed has since been removed, in addition a whole house audit has been completed by the facility's nursing team to identify residents with similar enablers. Any enablers not installed correctly, or not utilized will be removed no later than 4/11/2024. The Administrator or designee conducted education to staff regarding this violation on 3/26/2024. The staff educated included direct care staff and the education was based on the 2800 RCG as well as the literature published regarding enablers that released in 2023. This education will be kept in accordance to the PA 2800 regulations. Moving forward the administrator/designee will audit the resident's rooms who have enablers monthly to ensure they are medically necessary and in good repair/safe. Audits begin 5/1/2024. Any enabler remaining will be reflected in the resident ASP. All residents with enabler's will be reviewed at the facility's quality management meetings, the next meeting is scheduled for the last week of April. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

92 Windows/screens

8. Requirements

2800.

92 Windows/screens *(continued)*

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 2/27/24 at approximately 10:30 AM, there was no screen present in the window located in the hallway near living unit #230. Also, this window is unable to stay open independently and slams shut when opened. There is a sign near the window indicating "do not open window", as well as a 2"x4" board leaning against the window which appears to support the window when opened.

REPEAT VIOLATION: 4/20/2023

Plan of Correction ***Directed (- 04/16/2024)***

Please review this violation as it is cited as a repeat violation from 4/20/2023. The facility is now under new ownership with a new license number and it is our understanding the facility cannot be cited for a repeat violation if that violation occurred under a different legal entity.
Since the time of inspection this window has since been taken out of service while awaiting repair and the screen placed back in the window. Due to multiple weather related issues this window was being used as roof access by the facility's maintenance department and is currently on an unoccupied unit. A baseline audit of operable windows will be completed no later than 5/1/2024 by the administrator/designee. The administrator or designee completed education to the maintenance department on 4/2/2024 regarding this window. This education will be kept in accordance to the PA 2800 regulations. Moving forward the administrator or designee will be conducting environmental rounds as part of the facility's day to day operations. Once the baseline is completed, 10 windows will be audited weekly x 6 weeks to ensure the windows are in good working condition and have screens installed. (DIRECTED: The weekly audits of 10 windows per week shall begin on 4/22/24. 4/16/24). After the weekly audits are completed monthly window audits will be completed beginning the week of 6/19/24 as part of routine environmental audits. Any issues found during auditing will be brought to the attention to the maintenance department and be repaired as applicable. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

DIRECTED: By 5/1/24: The administrator shall ensure the window located in the hallway near living unit #230 is repaired to be able to stay open on its own and that the "do not open window" sign is removed. 4/16/24

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented (- 06/07/2024)

101j7 Lighting/operable lamp

9. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 2/27/24 at 11:27 AM, resident #8's bedside lamp was inoperable.

101j7 Lighting/operable lamp *(continued)*

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

Prior to the conclusion of the inspection, on approximately 2/28/24, this resident's lamp was operable. The light bulb was replaced by maintenance staff and the lamp worked appropriately. The Administrator or designee conducted education to staff regarding this violation on 3/26/2024, which was based on the 2800 RCG and the requirements for resident's to have an operable light source. This education will be kept in accordance to the PA 2800 regulations. As part of the facility's previous plan of correction and licensing, the administrator/designee has been conducting rounding of the facility to ensure resident rooms are in good working order. All resident rooms in the MIU were audited prior to 4/1/2024 to ensure all lamps/lighting were working. Moving forward the administrator/designee will add 10 resident rooms to be audited weekly until all resident rooms have been audited beginning 4/8/24. After those rooms are audited the facility will continue to conduct the routine rounding that is taking place currently as part of previous POC/licensing this routine rounding is happening daily and includes no less than 3 resident rooms being audited. These audits are conducted by the administrator/designee. Residents who reside in the MIU will have all of their rooms audited monthly indefinitely for general environmental rounds due to the nature of the unit and the potential inability for residents to communicate repairs needed. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

103g Storing food

10. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 2/28/24 at approximately 3:00 PM, numerous open and unsealed food items were present in the stand-up Turbo air freezer, to include the following items:

- *1 box of beef patties, which contained 11 patties*
- *1 box of chicken patties, which contained 16 patties*

On 2/28/24 at approximately 3:00 PM, numerous open and unsealed food items were present in the walk-in freezer, to include the following items:

- *A 20 lb. Box of California blend vegetables, approximately ½ full*
- *A 20 lb. box of broccoli cuts, approximately ¼ full*
- *A 13.5 lb. box of frozen french toast, approximately ¾ full*
- *A 15.75 lb. box of cheddar cheese omelets, approximately ¾ full*

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

The day of inspection the facility underwent an acute change in leadership in the dietary department which was a driving factor in the violations found in the kitchen. Since the time of inspection the dietary department is being led by regional dietary leadership until the new director and assistant director start their employment. The foods cited in this violation were correctly stored the day of the inspection. The kitchen underwent an additional inspection as

103g Storing food (continued)

part of a partial inspection conducted shortly after the conclusion of the renewal and no violations were cited. Moving forward the administrator will work with dietary leadership to conduct daily audits x 6 weeks to ensure food storage is appropriate. (DIRECTED: The daily audits of all food storage areas shall begin on 4/20/24. [redacted] 4/16/24). The Administrator or designee conducted education based on the 2800 RCG regarding food storage, to staff regarding this violation beginning 3/26/2024. This education will be kept in accordance to the PA 2800 regulations. This POC will be reviewed with the new dietary leadership when they start their employment to ensure the standards of care are upheld moving forward. Dietary staff will also receive education no later than 4/23/2024 regarding food storage. (DIRECTED: Documentation of the dietary staff education shall be kept in accordance with 2800.65L. [redacted] 4/16/24). Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *04/23/2024*

Implemented ([redacted] - 06/07/2024)

107d Procedure EMA submission

11. Requirements

2800.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The residence's written emergency procedures have not been reviewed and submitted to the local emergency management agency since 1/25/21.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Unfortunately the emergency preparedness binder used to cite this violation was pulled from the facility's closed unit, which has not had residents residing on the floor since at least 2021. The EOP was reviewed in November of 2023 and appropriately sent to local EMA. However, due to the violation, the EOP will be resubmitted to the local EMA no later than 4/19/2024. (DIRECTED: Documentation of submission to the local emergency management agency shall be kept. [redacted] 4/16/24). The Administrator or designee conducted education based on the requirements of the 2800 RCG to direct care staff regarding this violation on 3/26/2024. This education will be kept in accordance to the PA 2800 regulations. Moving forward the administrator/designee will ensure this documentation is sent annually or as changes are made, and will conduct monthly audits x 3 months to ensure all EOP binders accurately reflect the last date the EOP was reviewed/updated. The home will ensure compliance by creating a spreadsheet that tracks the last date of submission, which will be managed by the administrator/designee. (DIRECTED: The administrator shall create and implement the spreadsheet by 4/20/24. Documentation of the spreadsheet shall be kept and shall be reviewed during each of the home's quality management reviews to ensure compliance with 2800.107(d). [redacted] 4/16/24). Changes to the EOP will be reviewed at the facility's quality management meetings. The next scheduled meeting will be conducted the last week of April. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

107d Procedure EMA submission *(continued)*

Directed Completion Date: *04/23/2024*

Implemented ([redacted] - 06/07/2024)

132b Safety inspection/fire drill

12. Requirements

2800.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The most recent fire safety inspection and fire drill conducted by a fire safety expert was completed on 2/16/22.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Upon receipt of the LIS, regional operations reached out to Johnstown safety services as a provider to complete a fire inspection, supervised drill, and provide some education to the administration/maintenance department, and at a later date as part of annual requirements, the staff of the facility. On 4/1/2024 Johnstown safety services conducted a full fire inspection, conducted a supervised fire drill, and provided some education on alternate exits, meeting places, evacuation time, and the general documentation of a fire drill to those responsible for documenting drills. (DIRECTED: Documentation of the most recent fire safety inspection and supervised fire drill conducted by a fire safety expert shall be kept. [redacted] 4/16/24). This 4/1/24 fire drill is going to be used as the facility's March drill (in the 5 day window) per conversation with DHS regional supervisor. (DIRECTED: By 4/30/24: The residence shall conduct an unannounced fire drill for the month of April 2024. Documentation of the fire drill shall be kept in accordance with 2800.132c. [redacted] 4/16/24). The facility's drill was successful and within the facility's evacuation time determined at the time of the fire inspection to be 12 minutes. Evacuation included all residents to designated meeting spaces and multiple exits were used in the drill. Moving forward the administrator/designee will be auditing all things related to fire drills on a monthly basis within 72 hours of each drill, indefinitely, beginning in April of 2024. These audits will include the date of annual fire safety inspections/supervised drills and all things related to fire drill documentation. (DIRECTED: Beginning on 4/30/24: The administrator shall initial and date the residence's fire drill logs during each of the monthly fire drill record reviews. [redacted] 4/16/24). As part of the facility's monitoring step, the administrator/designee will be present for the April drill to monitor that the drill is successful and within the time frame. If issues arise an additional fire drill will be ran to correct issues. . The Administrator or designee conducted education to direct care staff responsible for responding to fire drills regarding this violation on 3/26/2024 in regards to staff responsibilities in a fire drill and the requirements listed in the 2800.132 section. This education will be kept in accordance to the PA 2800 regulations. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Implemented ([redacted] - 06/07/2024)

132c Fire drill records

13. Requirements

2800.

132c Fire drill records *(continued)*

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

Description of Violation

The fire drill records for the following fire drills do not include the amount of time it took for evacuation, the exit routes used, the number of residents in the residence at time of the drill or the number of residents evacuated:

- *1/6/24 at 4:00 PM*
- *12/15/23 at 10:20 AM*
- *12/1/23 at 8:00 PM*
- *11/7/23 at 1:00 PM*
- *10/4/23 at 4:00 AM*
- *9/13/23 at 3:00 AM*
- *8/29/23 at 10:00 AM*
- *7/10/23 at 5:40 AM*

The fire drill record for the fire drill conducted on 2/29/24 at 10:00 AM does not include the exit routes used or the number of residents that were evacuated.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Upon receipt of the LIS, regional operations reached out to Johnstown safety services as a provider to complete a fire inspection, supervised drill, and provide some education to the administration/maintenance department, and at a later date as part of annual requirements, the staff of the facility. On 4/1/2024 Johnstown safety services conducted a full fire inspection, conducted a supervised fire drill, and provided some education on alternate exits, meeting places, evacuation time, and the general documentation of a fire drill to those responsible for documenting drills. This 4/1/24 fire drill is going to be used as the facility's March drill (in the 5 day window) per conversation with DHS regional supervisor. (DIRECTED: By 4/30/24: The residence shall conduct an unannounced fire drill for the month of April 2024. Documentation of the fire drill shall be kept in accordance with 2800.132c. [redacted] 4/16/24). The facility's drill was successful and within the facility's evacuation time determined at the time of the fire inspection to be 12 minutes. Evacuation included all residents to designated meeting spaces and multiple exits were used in the drill. Moving forward the administrator/designee will be auditing all things related to fire drills on a monthly basis within, 72 hours of each drill, indefinitely, beginning in April of 2024. (DIRECTED: Beginning on 4/30/24: The administrator shall initial and date the residence's fire drill logs during each of the monthly fire drill record reviews. [redacted] 4/16/24). These audits will include the date of annual fire safety inspections/supervised drills and all things related to fire drill documentation. As part of the facility's monitoring step, the administrator/designee will be present for the April drill to monitor that the drill is successful and within the time frame. If issues arise an additional fire drill will be ran to correct issues. . The Administrator or designee conducted education to direct care staff responsible for responding to fire drills regarding this violation on 3/26/2024 in regards to staff responsibilities in a fire drill and the requirements listed in the 2800.132 section. This education will be kept in accordance to the PA 2800 regulations. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

132d Evacuation

14. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

The residence does not have written documentation from a fire safety expert within the past year indicating an evacuation time that exceeds 2 minutes, 30 seconds to evacuate residents to a public thoroughfare or to a fire-safe area designated in writing within the past year by a fire safety expert. The fire drill records for the following fire drills do not include the amount of time it took for evacuation, so it is unable to be determined if all residents evacuated within 2 minutes, 30 seconds:

- *1/6/24 at 4:00 PM*
- *12/15/23 at 10:20 AM*
- *12/1/23 at 8:00 PM*
- *11/7/23 at 1:00 PM*
- *10/4/23 at 4:00 AM*
- *9/13/23 at 3:00 AM*
- *8/29/23 at 10:00 AM*
- *7/10/23 at 5:40 AM*

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Upon receipt of the LIS, regional operations reached out to Johnstown safety services as a provider to complete a fire inspection, supervised drill, and provide some education to the administration/maintenance department, and at a later date as part of annual requirements, the staff of the facility. On 4/1/2024 Johnstown safety services conducted a full fire inspection, conducted a supervised fire drill, and provided some education on alternate exits, meeting places, evacuation time, and the general documentation of a fire drill to those responsible for documenting drills. This 4/1/24 fire drill is going to be used as the facility's March drill (in the 5 day window) per conversation with DHS regional supervisor. (DIRECTED: By 4/30/24: The residence shall conduct an unannounced fire drill for the month of April 2024. Documentation of the fire drill shall be kept in accordance with 2800.132c. [redacted] 4/16/24). The facility's drill was successful and within the facility's evacuation time determined at the time of the fire inspection to be 12 minutes. Evacuation included all residents to designated meeting spaces and multiple exits were used in the drill. Moving forward the administrator/designee will be auditing all things related to fire drills on a monthly basis within, 72 hours of each drill, indefinitely, beginning in April of 2024. (DIRECTED: Beginning on 4/30/24: The administrator shall initial and date the residence's fire drill logs during each of the monthly fire drill record reviews. [redacted] 4/16/24). These audits will include the date of annual fire safety inspections/supervised drills and all things related to fire drill documentation. As part of the facility's monitoring step, the administrator/designee will be present for the April drill to monitor that the drill is successful and within the time frame. If issues arise an additional fire drill will be ran to correct issues. . The Administrator or designee conducted education to direct care staff responsible for responding to fire drills regarding this violation on 3/26/2024 in regards to staff responsibilities in a fire drill and the requirements listed in the 2800.132 section. This education will be kept in accordance to the PA 2800 regulations. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

132f Alternate exit routes

15. Requirements

2800.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The fire drill records for the following fire drills do not include the exit routes used, so it is unable to be determined if alternate exit routes were used during each of the monthly fire drills:

- *2/29/24 at 10:00 AM*
- *1/6/24 at 4:00 PM*
- *12/15/23 at 10:20 AM*
- *12/1/23 at 8:00 PM*
- *11/7/23 at 1:00 PM*
- *10/4/23 at 4:00 AM*
- *9/13/23 at 3:00 AM*
- *8/29/23 at 10:00 AM*
- *7/10/23 at 5:40 AM*

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Upon receipt of the LIS, regional operations reached out to Johnstown safety services as a provider to complete a fire inspection, supervised drill, and provide some education to the administration/maintenance department, and at a later date as part of annual requirements, the staff of the facility. On 4/1/2024 Johnstown safety services conducted a full fire inspection, conducted a supervised fire drill, and provided some education on alternate exits, meeting places, evacuation time, and the general documentation of a fire drill to those responsible for documenting drills. This 4/1/24 fire drill is going to be used as the facility's March drill (in the 5 day window) per conversation with DHS regional supervisor. (DIRECTED: By 4/30/24: The residence shall conduct an unannounced fire drill for the month of April 2024. Documentation of the fire drill shall be kept in accordance with 2800.132c. [redacted] 4/16/24). The facility's drill was successful and within the facility's evacuation time determined at the time of the fire inspection to be 12 minutes. Evacuation included all residents to designated meeting spaces and multiple exits were used in the drill. Moving forward the administrator/designee will be auditing all things related to fire drills on a monthly basis within, 72 hours of each drill, indefinitely, beginning in April of 2024. (DIRECTED: Beginning on 4/30/24: The administrator shall initial and date the residence's fire drill logs during each of the monthly fire drill record reviews. [redacted] 4/16/24). These audits will include the date of annual fire safety inspections/supervised drills and all things related to fire drill documentation. As part of the facility's monitoring step, the administrator/designee will be present for the April drill to monitor that the drill is successful and within the time frame. If issues arise an additional fire drill will be ran to correct issues. . The Administrator or designee conducted education to direct care staff responsible for responding to fire drills regarding this violation on 3/26/2024 in regards to staff responsibilities in a fire drill and the requirements listed in the 2800.132 section. This education will be kept in accordance to the PA 2800 regulations. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

132h Designated meeting place

16. Requirements

2800.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

The fire drill records for the following fire drills do not include number of residents in the residence at the time of the fire drills or the number of residents that were evacuated, so it is unable to be determined if all residents evacuated to a designated meeting place away from the building or within a fire-safe area during each of the monthly fire drills:

- *1/6/24 at 4:00 PM*
- *12/15/23 at 10:20 AM*
- *12/1/23 at 8:00 PM*
- *11/7/23 at 1:00 PM*
- *10/4/23 at 4:00 AM*
- *9/13/23 at 3:00 AM*
- *8/29/23 at 10:00 AM*
- *7/10/23 at 5:40 AM*

The fire drill record for the fire drill conducted on 2/29/24 at 10:00 AM indicates 70 residents were present in the residence at the time of the fire drill; however, the fire drill record indicates 0 residents were evacuated.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Upon receipt of the LIS, regional operations reached out to Johnstown safety services as a provider to complete a fire inspection, supervised drill, and provide some education to the administration/maintenance department, and at a later date as part of annual requirements, the staff of the facility. On 4/1/2024 Johnstown safety services conducted a full fire inspection, conducted a supervised fire drill, and provided some education on alternate exits, meeting places, evacuation time, and the general documentation of a fire drill to those responsible for documenting drills. This 4/1/24 fire drill is going to be used as the facility's March drill (in the 5 day window) per conversation with DHS regional supervisor. (DIRECTED: By 4/30/24: The residence shall conduct an unannounced fire drill for the month of April 2024. Documentation of the fire drill shall be kept in accordance with 2800.132c. [redacted] 4/16/24). The facility's drill was successful and within the facility's evacuation time determined at the time of the fire inspection to be 12 minutes. Evacuation included all residents to designated meeting spaces and multiple exits were used in the drill. Moving forward the administrator/designee will be auditing all things related to fire drills on a monthly basis within, 72 hours of each drill, indefinitely, beginning in April of 2024. These audits will include the date of annual fire safety inspections/supervised drills and all things related to fire drill documentation. (DIRECTED: Beginning on 4/30/24: The administrator shall initial and date the residence's fire drill logs during each of the monthly fire drill record reviews. [redacted] 4/16/24). As part of the facility's monitoring step, the administrator/designee will be present for the April drill to monitor that the drill is successful and within the time frame. If issues arise an additional fire drill will be ran to correct issues. . The Administrator or designee conducted education to direct care staff responsible for responding to fire drills regarding this violation on 3/26/2024 in regards to staff responsibilities in a fire drill and the requirements listed in the 2800.132 section. This education will be kept in accordance to the PA 2800 regulations. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

141a Medical evaluation

17. Requirements

2800.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
12. Information about a resident's day-to-day assisted living service needs.

Description of Violation

Resident #4 was admitted to the residence on [redacted]; however resident #4's medical evaluations, dated [redacted]3 and [redacted], do not indicate that resident #4 had a tuberculin skin test completed within the last 2 years. These sections on both of resident #4's medical evaluations are blank.

REPEAT VIOLATION: 8/28/2023, et. al.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

At the time of inspection it was explained to the licensing representatives that this citation was cited on the facility's 2/5/24 inspection and that a plan of correction was in place to conduct a clinic to update all residents who need an annual PPD. Education is to be provided no later than 4/19/24 to staff responsible for ADMEs, this education will be based on the 2800 regulation and be conducted by the Saber Regional team. This education will be kept in accordance with 2800.65L. This resident has since received their PPD around 2/28/24 and the ADME was updated to reflect. Moving forward the administrator/designee will audit the ADME's monthly to ensure all information on the ADME is accurate and up to date. (DIRECTED: The monthly audits shall begin on 4/22/24 and shall include a review of at least 15 resident records per month to ensure each resident has a medical evaluation completed with includes all information specified in 2800.141(a). [redacted] 4/16/24). Additionally all new admissions will have their ADME reviewed within 7 days of admission to ensure the information regarding their PPD is up to date and within the timeframe allotted based on the 2800 RCG. (DIRECTED: The reviews of new admission medical evaluations shall begin on 4/22/24. [redacted] 4/16/24). These audits are ongoing and will continue as part of the facility's day to day operations. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

DIRECTED: By 4/25/24: The administrator shall develop and implement a new admission checklist to ensure a medical evaluation is completed in its entirety for all new admissions, which includes all items specified in 2800.141(a), within 60 days prior to admission in accordance with 2800.22(a). Copies of the completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process

141a Medical evaluation (continued)

shall be education on the new checklist by 4/25/24. Documentation of the education shall be kept in accordance with 2800.65L. [redacted] 4/16/24

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *04/25/2024*

Not Implemented ([redacted] - 06/07/2024)

141b1 Annual medical evaluation

18. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #3's most recent medical evaluation, dated [redacted] indicates resident #3 has not had a tuberculin skin test since [redacted]

On 2/27/24, bilateral enablers were present at the top of resident #7's bed; however, resident #7's most recent medical evaluation, dated [redacted], indicates resident #7 does not require specific body positioning and/or movement stimulation.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

At the time of inspection it was explained to the licensing representatives that this citation was cited on the facility's 2/5/24 inspection and that a plan of correction was in place to conduct a clinic to update all residents who need an annual PPD. This resident has received [redacted] PPD upon return the week of 4/8/24. (DIRECTED: Documentation of resident #3's tuberculin skin test shall be kept in resident #3's record. [redacted] 4/16/24). Additionally, the enabler's identified in this violation have been removed from the bed all together around 2/28/2024, due to removal, this resident's ADME accurately reflects the care that is needed. Education is to be provided no later than 4/19/24 to staff responsible for ADMEs, this education will be based on the 2800 regulation and be conducted by the Saber Regional team. This education will be kept in accordance with 2800.65L.Moving forward the administrator/designee will audit the ADME's monthly to ensure all information on the ADME is accurate and up to date. (DIRECTED: The monthly audits shall begin on 4/22/24 and shall include a review of at least 15 resident records per month to ensure each resident has a medical evaluation completed in its entirety in accordance with 2800.141(b). [redacted] 4/16/24). These audits are ongoing and will continue as part of the facility's day to day operations. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

DIRECTED: By 4/25/24: The administrator shall develop and implement a tracking system which includes the names of all residents and the dates of their most recent completed medical evaluations. Documentation of the tracking system shall be kept and shall be reviewed and updated monthly by the administrator/designee to ensure compliance with 2800.141(b). The tracking system shall also be reviewed during each of the home's quality management reviews. Documentation of the reviews shall be kept. [redacted] 4/16/24).

Proposed Overall Completion Date: 05/01/2024

141b1 Annual medical evaluation *(continued)*

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

184a Resident meds labeled

19. Requirements

2800.
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 #3 is prescribed Aspart insulin pen 100u/ml-Inject 2 units subcutaneously 3 times a daily before meals (give when blood sugar is over 151-200); however, resident #3's pharmacy label indicates Novolog flexpen 100u/ml-Inject subcutaneously 3 times daily in accordance with the following sliding scale: 70-89=2 units; 90-119=13 units; 120-150=14 units; 151-200=15 units; 201-250=16 units; 251-300=17 units; 301-350=18 units; 351-400=19 units; 401-450=20 units; 451-500=21 units; >500=call doctor and supervisor.

On 2/6/24, resident #4 was prescribed Ondansetron 4 mg tablet-Take 1 tablet by mouth every 8 hours. On 2/28/24, there were 2 packages of this medication present in the medication cart; however, 1 of the pharmacy labels on 1 of the packages indicated Ondansetron 4 mg tablet-Take 1 tablet by mouth every 6 hours.

REPEAT VIOLATION: 8/28/2023, et. al.; 8/2/2023, et. al.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

The physician for Resident #3 was contacted by LPN supervisor on February 28, 2024. The physician reviewed and revised the order for the Aspart Insulin Pen. The pharmacy services for Resident #3 was contacted by the LPN supervisor on February 28, 2024, and the medication with revised label was received by the facility that correctly reflects the clarified physician order. The physician for Resident #4 was contacted by the LPN supervisor on February 28, 2024. The physician reviewed the order for Ondansetron, 4 mg. tablet by mouth every 8 hours and confirmed that the scheduled medication frequency will remain the same. The LPN supervisor on February 28, 2024, placed a "Direction Change – Refer to MAR" sticker on the medication label.
The Regional Support staff along with facility clinical leadership conducted a full house physician order to label review to ensure that the medication label correctly reflects the physician order. This was completed by April 5, 2024.
The nurses and med techs will be educated by the Regional Support Staff and facility leadership on regulation 2800.184a and their responsibility to compare physician order to medication label. This will be completed by April 21, 2024. Education will be kept in accordance to the PA 2800 regulations.

184a Resident meds labeled (continued)

The facility Administrator/designee will run a new physician order report weekly and will audit that the medication label is correct. This audit will begin the third week of April, 2024 and be performed weekly. New order audit will be continued on a weekly basis to monitor for compliance. Any issue identified through the auditing will be corrected immediately. The Administrator/designee will continue to perform, at minimum, three random weekly medication pass observations to monitor medication administration and monitor that medications are labeled and reflective of the physician order. (DIRECTED: Beginning on 4/18/24: Documentation of the weekly medication administration observations shall be kept for 2 months. [redacted] 4/16/24). Medication pass audits started in the facility in January, 2024 and will continue indefinitely to monitor compliance with medication administration and labeling. Audit results will be reviewed and discussed as part of the facility's monthly Quality Management Review which will be held on April 23, 2024.

The Regional Support staff along with facility clinical leadership conducted a full house physician order to label review to ensure that the medication label correctly reflects the physician order. This was completed by April 5, 2024. The nurses and med techs will be educated by the Regional Support Staff and facility leadership on regulation 2800.184a and their responsibility to compare physician order to medication label. This will be completed by April 11, 2024. Education will be kept in accordance to the PA 2800 regulations.

The facility Administrator/designee will run a weekly new physician order report and will audit that medication labels are correct. This audit will begin the first week of April, 2024 and be performed weekly [redacted] - (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] 4/16/24). Any issue identified through the auditing will be corrected immediately. The Administrator/designee will continue to perform random weekly medication pass observations to monitor medication administration and monitor that medications are labeled and reflective of the physician order. Audit results will be reviewed and discussed as part of the facility Quality Management Review.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

185a Storage procedures

20. Requirements

2800.
185.a. The residence 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 #9 is prescribed Ondansetron 4 mg tablet-Take 1 tablet by mouth every 4 hours as needed; however, on 2/28/24, this medication was not present in the residence and available for administration.

REPEAT VIOLATION: 8/28/2023, et. al.; 8/2/2023, et. al.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

The medication for Resident #9 had depleted during the medication pass after the morning administration. The staff immediately reordered the medication from the pharmacy which arrived on the evening delivery. The medication

185a Storage procedures (continued)

arrived the same day before the next scheduled dose.
The Regional Support staff along with facility clinical leadership conducted a full house physician order to cart review to ensure that medications ordered were available in the medication cart. This was completed by April 5, 2024.
Nurses and med techs will be educated by the Regional Support Staff and facility leadership on 2800.185a and their responsibility to reorder medications prior to the last dose packaged. This education will be completed by April 21, 2024. Education will be kept in accordance to the PA 2800 regulations.
The Administrator/designee will audit medication carts weekly to ensure that medication is reordered prior to the last packaged dose. This audit will focus on multidose medications (eye drops, inhalers, nasal sprays, creams, etc), and those resident's whose pharmacy provider does not utilize an autofill process. This audit will be performed weekly beginning the third week of April [redacted] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] 4/16/24). This audit will continue on a weekly basis indefinitely to audit compliance. Any issue identified through the auditing will be corrected immediately. The Administrator/designee will continue to perform, at minimum, three random weekly medication pass observations to monitor medication administration and to monitor that medications are timely reordered. Medication pass audits started in February, 2024 and will continue indefinitely to audit compliance. (DIRECTED: Beginning on 4/18/24: Documentation of the weekly medication administration observations shall be kept for 2 months. [redacted] 4/16/24). Audit results will be reviewed and discussed as part of the facility's monthly Quality Management Review which will be held on April 23,2024

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

187b Date/time of med admin

21. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 2/13/24 at approximately 9:30 PM, resident #5 was administered the following medications; however, the medications were not documented as administered on resident #5's February 2024 MAR:

- *Basgalar Kwikpen 100u/ml-Inject 60 units subcutaneously at bedtime*
- *Famotidine 40 mg tablet-Take 1 tablet by mouth at bedtime*

REPEAT VIOLATION: 9/26/2023, et. al.; 8/2/2023, et. al.

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

The medication for Resident #5 was administered but not initialed on the medication administration record. Staff member received education on February 14, 2024 by the Administrator/designee on the rights of medication administration which includes proper documentation.
The Regional Staff Support and the facility leadership will educate nurses and med techs on 2800.187b, rights of medication administration, and their responsibility to document that medication administration is completed. This education will be completed by April 21, 2024. Education will be kept in accordance to PA 2800 regulations.
The Administrator/designee utilizes a Medication Administration Compliance report to monitor that proper documentation is completed. This report review began in January, 2024 and will be completed, at minimum, twice

187b Date/time of med admin (continued)

weekly starting the third week of April, 2024 and will continue for three months and then indefinately to audit compliance. Any issue identified through this auditing will be corrected immediately. Audit results will be reviewed and discussed as part of the facility Quality Management Review which will be held on April 23, 2024.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented (- 06/07/2024)

225b Assessment content

22. Requirements

2800.
225.b. The assessment must, at a minimum include the following:

1. The resident's need for assistance with ADLs and IADLs.
2. The mobility needs of the resident.
3. The ability of the resident to self-administer medication.
4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.
5. The resident's need for supplemental health care services.
6. The resident's need for special diet or meal requirements.
7. The resident's ability to safely operate key-locking devices.

Description of Violation

Resident #5's assessment, finalized on , does not include an assessment of resident #5's orientation to time, place, and person. This section of resident #5's assessment is blank. Resident #5's support plan, finalized on indicates resident #5 cannot find room at times.

Resident #6's most recent medical evaluation, dated , indicates resident #6 is prescribed a pureed diet with nectar thick liquids; however, resident #6's most recent assessment, dated , indicates resident #6 is prescribed a regular diet.

Plan of Correction ***Directed (- 04/16/2024)***

Prior to the inspection the facility had conducted and completed audits of all ASP's in December of 2023. These residents were identified previous as individuals without an ASP, the Administrator and designee worked in the month of January to ensure all residents had a current ASP. The ASP being cited for resident #5 was finalized by the previous legal entity and is not the updated 2024 ASP that was provided to the licensing representatives at the time of inspection. The facility cannot speak to ASP created from previous legal entities. This resident's 2024 ASP was created and has the information cited in the appropriate categories. Additionally, resident #6's ASP was reviewed and updated to reflect the correct information on or around 2/28/2024. The Administrator or designee conducted education to direct care staff regarding this violation on 3/26/2024 based on the 2800 RCG content. Education will also be provided no later than 4/19/24 to staff responsible for ASP creation, this will be conducted by saber's regional team. This education will be kept in accordance to the PA 2800 regulations. Moving forward the administrator/designee are reviewing ASPs monthly based on the spreadsheet created during the 2023 provisional licensing audits completed by the facility to ensure that the system in place for ASP updates is followed and the information provided in the ASP most accurately reflects the care needed. (DIRECTED: The monthly audits shall begin on 4/22/24 and shall include a review of at least 15 resident records per month to ensure each resident has an accurate and complete assessment/support plan completed in its entirety in accordance with 2800.225(b). 4/16/24). This ASP review has been taking place since December of 2023 and will continue indefinitely as part of

225b Assessment content (continued)

the facility's day to day operations. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

DIRECTED: By 4/25/24: The administrator shall develop and implement a system to ensure resident assessments and support plans are updated as resident care needs change. Documentation of the system shall be kept. All staff persons involved in the completion of resident assessments/support plans shall be educated on the new system by 4/25/24. Documentation of the education shall be kept in accordance with 2800.65L. [redacted] 4/16/24).

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

226a Mobility – assessment

23. Requirements

2800.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #4's most recent medical evaluation, dated [redacted], indicates resident #4 has total mobility needs and requires dementia care in the home's special care unit (SCU); however, resident #4's most recent assessment, dated [redacted] indicates resident #4 has minimal mobility needs.

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Prior to the inspection the facility had conducted and completed audits of all ASP's in December of 2023. These residents were identified previous as individuals without an ASP, the Administrator and designee worked in the month of January to ensure all residents had a current ASP. This resident's ASP has been updated to reflect the resident's mobility status accurately. The Administrator or designee conducted education to direct care staff regarding this violation on 3/26/2024 based on the 2800 RCG content. Additional education will be provided to those staff responsible for creating ASP, and will be conducted by the saber regional team. (DIRECTED: The additional education for those staff persons responsible for creating resident assessments/support plans shall be completed by 4/25/24. [redacted] 4/15/24). This education will be kept in accordance to the PA 2800 regulations. Moving forward the administrator/designee are reviewing all resident ASPs monthly to ensure that the system in place for ASP updates is followed and the information provided in the ASP most accurately reflects the care needed. Moving forward the administrator/designee are reviewing ASPs monthly based on the spreadsheet created during the 2023 provisional licensing audits completed by the facility to ensure that the system in place for ASP updates is followed and the information provided in the ASP most accurately reflects the care needed. Monthly reviews began in January of 2024. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.

DIRECTED: By 4/25/24: The administrator shall develop and implement a system to ensure resident assessments and support plans are updated as resident care needs change, which includes changes to resident mobility status. Documentation of the system shall be kept. All staff persons involved in the completion of resident assessments/support plans shall be educated on the new system by 4/25/24. Documentation of the education

226a Mobility – assessment (continued)

shall be kept in accordance with 2800.65L. [redacted] 4/16/24).

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

227g Support plan - signatures

24. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #5's support plan, finalized on [redacted], is not signed by anyone, including the assessor or resident #5.

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

Prior to the inspection the facility had conducted and completed audits of all ASP's in December of 2023. This resident was identified as an individual without a current ASP, the Administrator and designee worked in the month of January to ensure all residents had a current ASP. The ASP being cited for resident #5 was finalized by previous legal entity and is not the updated 2024 ASP that was provided to the licensing representatives at the time of inspection. The facility cannot speak to ASP created from previous legal entities as to why it was not completed correctly. This resident's 2024 ASP was created 1/27/24 and has been signed by the resident and assessor, and provided to the licensing representatives upon request of resident records. The Administrator or designee conducted education to staff regarding this violation on 3/26/2024. This education will be kept in accordance to the PA 2800 regulations. Moving forward the administrator/designee are reviewing all resident ASPs monthly to ensure that the system in place for ASP updates is followed and the information provided in the ASP most accurately reflects the care needed. Moving forward the administrator/designee are reviewing ASPs monthly based on the spreadsheet created during the 2023 provisional licensing audits completed by the facility to ensure that the system in place for ASP updates is followed and the information provided in the ASP most accurately reflects the care needed. Monthly reviews began in January of 2024. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

251b Record entries - legible

25. Requirements

2800.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid is present over the legal representative section on page 1 of resident #3's resident-residence contract, which was signed on [redacted].

Correction fluid is present on the date of the in-person evaluation and the date the medical evaluation was completed on resident #3's most recent medical evaluation, dated [redacted].

251b Record entries - legible (continued)

Correction fluid is present on the date in the resident signature section of resident #6's most recent assessment and support plan, dated [redacted].

Plan of Correction ***Accept ([redacted] - 04/16/2024)***

The original forms with correction fluid present have since been copied without correction fluid present on the paper, completed the week of 3/11/24. Originals with the fluid have been discarded and the copies without correction fluid have been filed. The Administrator or designee conducted education to direct care staff regarding this violation on 3/26/2024 based on 2800 RCG content. Additional education to be provided no later than 4/19/24 to staff responsible for creating ASP/ADME to ensure they are aware of the policy surrounding correction fluid. This will be conducted by the saber regional team. This education will be kept in accordance to the PA 2800 regulations. Administrator and nursing team will also receive education from regional staff regarding the use of correction fluid in the facility. This education will take place prior to 4/19/2024. Moving forward an audit of 10 resident records will be completed weekly to ensure correction fluid is not present on any medical form beginning the week of 4/15/24. Once all resident records have been audited the facility will then review new admission paperwork at its quality management meetings. The next meeting will take place the last week of April on 4/23/24, the documentation of the meeting will be kept.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Implemented ([redacted] - 06/07/2024)

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

Facility Information

Name: *THE VILLAGES OF HARMAR* **License #:** *45456* **License Expiration:** *06/21/2024*

Address: *715 FREEPORT ROAD, CHESWICK, PA 15024*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *THE VILLAGES OF HARMAR, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/24/2006* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *2* **Total Daily Staff:** *100* **Waking Staff:** *75*

Inspection Information

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

Reason: *Complaint, Provisional, Incident* **Exit Conference Date:** *04/01/2024*

Inspection Dates and Department Representative

03/25/2024 - On-Site: [redacted]

03/26/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *133* **Residents Served:** *74*

Special Care Unit

In Home: *Yes* **Area:** *1st floor* **Capacity:** *23* **Residents Served:** *20*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *74*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *24* **Have Physical Disability:** *2*

Inspections / Reviews

03/25/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/14/2024*

04/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/10/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/24/2024*

04/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/10/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/10/2024*

06/07/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/10/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

15b Resident abuse-superv plan

1. Requirements

2800.
15.b. If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted] at approximately [redacted] in the residence's special care unit (SCU), staff person D observed staff person A take a can of spray dust remover and spray resident #1 in the face and eyes; however, staff person A continued to work in the residence unsupervised until the end of the shift at [redacted]

Plan of Correction ***Directed ([redacted] - 04/25/2024)***

At the time of the incident staff member D felt retaliation could be possible and failed to report to the administrator at the time of the event. Staff member D is not able to suspend another employee therefore staff member A worked with staff person D the remainder of the shift. Upon notification by staff person D of the incident to facility leadership staff person A was suspended pending investigation. All appropriate reports were made and the facility substantiated the incident. Staff person A no longer works at the facility, terminated [redacted]. Education will be provided to direct care staff responsible to reporting abuse allegations to the facility's administrator/designee. This education will be kept in accordance to 2800.65l and will be completed no later than 5/1/24. (DIRECTED: The staff education shall include the residence's reporting procedures to ensure a plan of supervision or staff suspension is immediately developed and implemented for all staff persons involved in an allegation of abuse in accordance with the Older Adult Protective Services Act. [redacted] 4/25/24). As part of the facility monitoring, the Administrator/designee will interview 5 residents monthly x 6 months to ensure residents are free from abuse. The facility's next QM meeting was rescheduled from 4/23/24 to 4/25/24 due to DHS survey. (DIRECTED: Documentation of the quality management review shall be kept. [redacted] 4/25/24).

DIRECTED: Beginning on 4/29/24: The administrator/designee shall review all internal incidents daily to ensure all staff persons involved in allegations of abuse are immediately suspended or placed on a plan of supervision in accordance with the Older Adult Protective Services Act. [redacted] 4/25/24).

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

16c Incident reporting

2. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] at approximately [redacted] in the residence's SCU, staff person D observed staff person A take a can of spray dust remover and spray resident #1 in the face and eyes; however, this incident was not reported to the Department.

REPEAT VIOLATION: 8/28/23 et al.

16c Incident reporting *(continued)*

Plan of Correction ***Directed ([redacted] - 04/25/2024)***

This specific incident was reported to AAA and DHS the same day, however, the facility was unable to provide a fax confirmation at the time of inspection, resulting in the citation. All reports, act 13, statements, and investigation were provided for review. AAA received the report and investigated the incident on 1/16/2024. Reportable was resubmitted to DHS on 3/26/24. Education was provided to leadership responsible for reporting incidents to DHS. This education was provided by saber regional operator and included the process of reporting incidents, the categories of reportable incidents, and the timeliness required for the different times of reports. This education was completed on 4/17/24, and will be kept in accordance to 2800.65l. Since the time of this incident the facility's new clinical coordinator has implemented 24 hour reports which began approximately mid March of 2024. These reports allow for the facility clinical coordinator/designee to capture and review daily incidents in the facility within 24 hours. (DIRECTED: Beginning on 4/29/24: The administrator/designee shall review all internal incidents and the 24-hour reports daily to ensure all reportable incidents specified in 2800.16a are reported to the Department within 24 hours in accordance with 2800.16c. [redacted] 4/25/24). Moving forward the administrator will review all reportable prior to submission and the administrator/designee will email reportable to the appropriate address within the allotted time frame. These reviews began 4/11/24. This process will be implemented as a system the facility will follow indefinitely. Reportable incidents will be reviewed at the facility's QM meetings, the next meeting is held 4/23/24. Documentation will be kept of the QM meeting.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *04/29/2024*

Not Implemented ([redacted] - 06/07/2024)

17 Record confidentiality

3. Requirements

2800.

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

Description of Violation

On 3/25/24 at 10:03 AM, the privacy coding documents, which contained numerous resident names, were attached to the following license inspection summaries and were unlocked, unattended and accessible in the main lobby:

- *The license inspection summary, dated 8/2/23 et. al., which contained 8 resident names, including resident #2*
- *The license inspection summary, dated 8/28/23 et. al., which contained 42 resident names, including resident #2*
- *The license inspection summary, dated 9/26/23 et. al., which contained 12 resident names, including resident #2*

REPEAT VIOLATION: 9/26/2023, et. al.; 8/28/2023, et. al.

Plan of Correction ***Accept ([redacted] - 04/18/2024)***

Upon identification of the protected information, the records were removed immediately the day of inspection by the Administrator. Education was provided on 3/26/2024, by the Administrator or designee to staff with access to protected information, this education's documentation will be kept in accordance to the PA 2800 regulations. Each nurses station is equipped with locking drawers and those drawers will be utilized for any PHI needing to be stored at the nurses station. These drawers will be utilized effective 4/19/2024 Moving forward the Administrator or designee

17 Record confidentiality (continued)

will conduct daily rounding when in the facility, for all nursing stations and facility postings to ensure PHI is not accessible. This daily
rounding will be completed once per shift when able, but no less than daylight and evening shifts. Daily rounding began on 4/8/2024. This audit will take place indefinitely as part of the facility's daily operations. Audit results will be discussed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented (- 06/07/2024)

42b Abuse/Neglect

4. Requirements

2800.
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 at approximately in the residence's SCU, staff person D witnessed staff person A become angry at resident #1 due to resident #1's resistance to care and observed staff person A take a can of spray dust remover and spray resident #1 in the face and eyes.

On while in the residence's SCU, staff persons witnessed resident #1 swing and punch resident #3 in the eye after resident #3 touched resident #1's arm. According to resident #1's progress notes, resident #1 has displayed numerous other aggressive and violent behaviors in the residence, to include the following:

- *"[Resident #1] went up to another resident and starting punching the other resident"*
- *: "[Resident #1] is combative with staff, punching, scratching Tried to re direct multiple times"*
- *"[Resident #1] shower was scheduled today and when aide was getting in the shower room resident becoming aggressive towards aide and was pinching aide's arm and scratching"*
- *: "[Resident #1] has been yelling at others and spit in [resident #3]'s face and continues to yell at others, can't redirect at all"*
- *"Dr. in and saw [resident #1] due to eyes being red and having exudate. [Resident #1] became agitated and grabbed the doctors tie had to keep reassuring resident that this is a doctor and was here to exam eyes and listen to heart. then grabbed my finger and attempted to bend it in the opposite direction and finally let go"*
- *: "[Resident #1] was agitated, yelling at [resident #6] and punched in the face. I redirected, but continued to come out and yell at*
- *: "Pca informed this writer that after lunch [resident #1] grabbed [resident #4]'s face with whole hand resulting in red marks while [resident #4] was sitting in dining room"*

Also, according to incident reports submitted to the Department, resident #1 also displayed the following aggressive and violent behaviors towards other residents:

- *Resident #1 was observed exiting room, walked up to resident #5, yelled and struck resident #5 in the face and scratched hand*
- *: Resident #4 was in a common area when resident #1 came out of room. Resident #1 started yelling at resident #4, then pushed resident #4, who fell to the ground. Resident #4 was transported to the hospital and was admitted with*

42b Abuse/Neglect *(continued)*

Plan of Correction ***Directed (- 04/25/2024)***

Staff person A no longer works at the facility, terminated . During the investigation of this incident on Re-education will be provided by the administrator/designee on abuse, reporting abuse, signs of abuse, and the proper channels to report abuse. This education will take place no later than 5/10/24. Education will be done for direct care staff responsible for resident care, this education will be kept in accordance to pa 2800.65l. (DIRECTED: By 5/10/24: All current staff persons shall receive the education on abuse, reporting abuse, signs of abuse, and the proper channels to report abuse. Documentation of the education shall be kept in accordance with 2800.65l. 4/25/24). Resident #1's physician was contacted immediately by nursing leadership and the resident's medications were reviewed and adjusted to better meet the resident's needs. Moving forward the resident's behaviors will be reviewed daily x 2 months and weekly thereafter by clinical leadership beginning 4/25/24. Clinical leadership will contact the resident's physician as needed to review medication or make adjustments. Changes in behaviors will be addressed immediately. As part of the facility monitoring, the Administrator/designee will interview 5 residents monthly x 6 months to ensure residents are free from abuse. (DIRECTED: The weekly resident interviews shall begin on 4/29/24. Documentation of the resident interviews shall be kept. 4/25/24 Additional education will be provided to direct care staff no later than 5/1/24 regarding redirection techniques as well as how to deal with challenging behaviors that are sometimes seen on memory care units. In addition, person centered interventions will be discussed for resident #1 during these educations. Resident #1's ASP was updated by the previous administrator on 4/5/24. This education will be kept on file in accordance to 2800.65l. The facility's next QM meeting was rescheduled from 4/23/24 to 4/25/24 due to DHS survey. (DIRECTED: Documentation of the quality management review shall be kept. 4/25/24).

Proposed Overall Completion Date: 05/10/2024

Directed Completion Date: *05/10/2024*

Not Implemented (- 06/07/2024)

90b Staff commnication

5. Requirements

2800.
90.b. For a residence serving nine or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

Numerous staff persons indicated staff persons do not regularly use the residence's system of communication, which are walkie-talkies, to enable staff persons to immediately contact other staff persons in the residence for assistance in an emergency. On 3/25/24 and 3/26/24, the residence served 74 residents.

Plan of Correction ***Accept (- 04/18/2024)***

On 3/26/2024, the previous administrator provided education at shift change for staff members on how to utilize the walkie talkie function of the facility telephones. Formal education will be provided by the current administrator/designee no later than 4/25/24 to the direct care workers who carry phones so they are able to immediately communicate as needed. This education will be kept in accordance to 2800.65l. Moving forward the administrator/designee will conduct weekly audits to ensure the system is functioning appropriately x 6 weeks beginning the week of 4/22/24. After the six weeks of audits, the administrator will report any issues with the communication system to the residences maintenance department as well as IT if IT support is needed. Results of audits will be discussed at the facility QM meetings, the next scheduled meeting is 4/23/24. Documentation of this

90b Staff commnication (continued)

meeting will be kept in accordance to PA 2800 regulations.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented (- 06/07/2024)

141b1 Annual medical evaluation

6. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #3's most recent medical evaluation, dated indicates resident #3 has not had a tuberculin skin test completed since

Resident #1's most recent medical evaluation, dated , indicates resident #1 has not had a tuberculin skin test completed since

REPEAT VIOLATION: 1/23/2024, et. al.

Plan of Correction ***Directed (- 04/25/2024)***

Education is to be provided no later than 4/19/24 to staff responsible for ADMEs, this education will be based on the 2800 regulation and be conducted by the Saber Regional team. This education will be kept in accordance with 2800.65L. These residents will receive their annual PPD no later than 4/23/24 or sooner. (DIRECTED: Documentation of resident #1 and #3's most recent tuberculin skin tests shall be kept in each resident's record. 4/25/24).
Moving forward the administrator/designee will audit the ADME's monthly to ensure all information on the ADME is accurate and up to date. The monthly audits shall begin on 4/22/24 and shall include a review of at least 15 resident records per month to ensure each resident has a medical evaluation completed with includes all information specified in 2800.141(a). Additionally all new admissions will have their ADME reviewed within 7 days of admission to ensure the information regarding their PPD is up to date and within the timeframe allotted based on the 2800 RCG. The reviews of new admission medical evaluations shall begin on 4/22/24. These audits are ongoing and will continue as part of the facility's day to day operations. Audit results will be reviewed at the facility's next QM meeting on 4/23/2024. Documentation of the meeting will be kept.
By 4/25/24: The administrator shall develop and implement a new admission checklist to ensure a medical evaluation is completed in its entirety for all new admissions, which includes all items specified in 2800.141(a), within 60 days prior to admission in accordance with 2800.22(a). Copies of the completed new admission checklists shall be kept in each resident's record. In addition to the check list, the home will obtain standing orders for PPD tests for all residents scheduled every 2 years based on their most recent PPD, the clinical coordinator/nursing staff will input these orders into resident charts no later than 5/10/24. With these orders in the resident EMAR, the residence will have a built in tracking system that will notify nurses as PPDs are due. All staff persons involved in the admission process shall be education on the new checklist by 4/25/24. Documentation of the education shall be kept in accordance with 2800.65L.

Proposed Overall Completion Date: 05/10/2024

Directed Completion Date: *05/10/2024*

141b1 Annual medical evaluation *(continued)*

Not Implemented (- 06/07/2024)

[redacted]

- [redacted]
- [redacted]

Withdrawn B.S. 6/27/2024

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

190a Completion of course–meds

10. Requirements

2800.

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

Description of Violation

Staff person B successfully completed the Department-approved medications administration course on [redacted] *however, staff person B has not completed any annual practicums since February, 2023 in accordance with the Department-approved medication course. Staff person B has administered medications to numerous residents on numerous dates/times, to include the following medications to resident #8 on 3/2/24, 3/9/24 and 3/10/24 between 8:00 AM-10:00 AM:*

- *B complex Vitamin B12 tablet-Give 1 tablet by mouth daily*
- *Carvedilol 12.5 mg tablet-Give ½ tablet by mouth twice a day*
- *Montelukast 10 mg tablet-Give 1 tablet by mouth every day*

Staff person C has not successfully completed the Department-approved medications administration course; however, staff person C has administered medications to numerous residents on numerous dates/times, to include the following medications to resident #8:

- *Carvedilol 12.5 mg tablet-Give 1/2 tablet by mouth twice a day, which was administered to resident #8 by staff person C on 3/1/24, 3/8/24 and 3/12/24 between 8:00 PM and 10:00 PM*
- *Fenofibrate Nanocrystallized 145 mg tablet-Give 1 tablet by mouth at bedtime, which was administered to resident #8 by staff person C on 3/1/24, 3/8/24 and 3/12/24 between 8:00 PM and 10:00 PM*
- *Levothyroxine 50 mcg tablet-Give 1 tablet by mouth every day, which was administered to resident #8 by staff person C on 3/2/24 and 3/9/24 between 5:00 AM and 7:00 AM*

190a Completion of course–meds *(continued)*

Plan of Correction ***Directed (- 04/25/2024)***

Immediately, the administrator/designee contacted the individuals cited in this violation and removed them from the schedule until they were able to retake the medication administration course through a certified train the trainer. Additionally a baseline audit was completed on 3/26/24 to ensure all med techs were up to date with their annual practicum. Any med techs found through this audit were removed from the schedule to retake the medication administration course. As of 4/11/2024 all staff persons cited in this violation, and found in the audit have retaken the course and are recertified to pass medications. Moving forward the administrator/designee is tracking all annual practicum requirements and is in the process of creating a binder specific to medication trainings and expiration dates of all things meds. This includes diabetic training tracking and medication administration annual practicum dates. This binder will be equipped with a spreadsheet tracking expiration dates as a quick reference, and will be reviewed monthly indefinitely. Audits begin the week of 4/29/24. The administrator/designee will be auditing employee medtech records monthly (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. 4/25/24). to ensure all med techs are up to date with their annual practicum observations. Additionally, a certified train the trainer will provide education to clinical leadership no later than 4/23/24 on how to track annual practicum and what the process is to recertify med techs. This education will be kept in accordance to 2800.65. Results of audits will be reviewed at the facility's quality management meetings, and documentation will be kept. The next meeting is 4/23/2024.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *04/29/2024*

Not Implemented (- 06/07/2024)

190b Insulin injections

11. Requirements

2800.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person C has not successfully completed the Department-approved medications administration course or successfully completed the Department-approved diabetes patient education program within the past 12 months; however, staff person C administered insulin to resident #8 on numerous dates/times, to include the following:

- *14 units of Tresiba insulin 100u/ml on 3/8/24 and on 3/12/24 between 8:00 PM and 10:00 PM*
- *13 units of Aspart insulin 100u/ml on 3/8/24 between 4:00 PM and 5:00 PM*
- *16 units of Aspart insulin 100u/ml on 3/9/24 between 6:00 AM and 7:00 AM*
- *20 units of Aspart insulin 100u/ml on 3/12/24 between 4:00 PM and 5:00 PM*

190b Insulin injections *(continued)*

Plan of Correction ***Directed ([redacted] - 04/25/2024)***

Immediately the individual cited in this violation was instructed they were unable to administer insulin injections. On 4/11/2024 this individual along with others attended a diabetic education class hosted at the facility by a certified diabetic trainer. This individual successfully completed the course and is now up to date with their diabetic trainings. Moving forward the administrator/designee is tracking all diabetic education and is in the process of creating a binder specific to medication trainings and expiration dates of all things meds. This includes diabetic training tracking and medication administration annual practicum dates. This binder will be equipped with a spreadsheet tracking expiration dates as a quick reference, and will be reviewed monthly indefinitely. Audits begin the week of 4/29/24. The administrator/designee will be auditing employee medtech records monthly [redacted] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] 4/25/24). to ensure all med techs are up to date with their diabetic trainings. Additionally, a certified med tech train the trainer will provide education to clinical leadership no later than 4/23/24 on the requirements of annual diabetic trainings in accordance of PA 2800 regulations. This education will be kept in accordance to 2800.65. Results of audits will be reviewed at the facility's quality management meetings, and documentation will be kept. The next meeting is 4/23/2024.

Proposed Overall Completion Date: 05/01/2024

Directed Completion Date: *04/29/2024*

Implemented ([redacted] - 06/07/2024)

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

Facility Information

Name: *THE VILLAGES OF HARMAR* **License #:** *45456* **License Expiration:** *06/21/2024*

Address: *715 FREEPORT ROAD, CHESWICK, PA 15024*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *THE VILLAGES OF HARMAR, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/24/2006* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *94* **Waking Staff:** *71*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *04/24/2024*

Inspection Dates and Department Representative

04/23/2024 - On-Site: [redacted]

04/24/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *133* **Residents Served:** *71*

Special Care Unit

In Home: *Yes* **Area:** *1st floor* **Capacity:** *23* **Residents Served:** *21*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *71*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *23* **Have Physical Disability:** *0*

Inspections / Reviews

04/23/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/16/2024*

05/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/06/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/22/2024*

05/23/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/06/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/06/2024*

06/07/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/06/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

141b1 Annual medical evaluation

1. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

There is no documentation present in resident #1's record, including on resident #1's most recent medical evaluation, dated [redacted], indicating resident #1 has had a tuberculin skin test administered with negative results within the past 2 years.

REPEAT VIOLATION: 1/23/2024, et. al.

Plan of Correction ***Directed ([redacted] - 05/23/2024)***

The resident's [redacted] had the resident tested earlier in the year and would not allow the community to test the resident again. The [redacted] reported the test to be negative but failed to provide the proper documentation after repeated requests. The resident no longer resides at this community.
Immediate Action: On [redacted] all residents received a TB test. All results were negative and will be kept in the residents' charts. All TB tests will be completed prior to or within 15 days of admission. The Executive Director will follow the Resident Admission Checklist upon move-in. The Beginning on 05/20/22, Executive Director will audit newly admitted resident files within 15 days of admission to ensure that all required documentation, including TB testing with a negative result has been completed. The process and status of resident admissions will be covered during the monthly Quality Management Meeting on 05/30/24. (DIRECTED: Documentation of the quality management review shall be kept. [redacted] 5/23/24)

DIRECTED: By 6/6/24: All staff persons involved in the resident admission process shall be re-educated on the home's admission checklist to ensure each newly-admitted resident has a medical evaluation completed in its entirety within 60 days prior to admission, which includes documentation that a tuberculin skin test has been administered to the resident with negative results within the past 2 years. Documentation of the education shall be kept in accordance with 2800.65l. [redacted] 5/23/24

Proposed Overall Completion Date: 05/30/2024

Directed Completion Date: *06/05/2024*

Not Implemented ([redacted] - 06/07/2024)

183d Current medications

2. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 4/1/24, resident #3's Novolog flexpen insulin was discontinued; however, on 4/13/24 at approximately 12:00 PM, resident #3's Novolog was still present in the home and 14 units of the Novolog were administered to resident #3 in error.

183d Current medications (continued)

REPEAT VIOLATION: 1/23/2024 et al.; 8/28/2023 et al.; 8/2/2023 et al.

Plan of Correction ***Directed (- 05/23/2024)***

Immediate Action: The discontinued Novolog was immediately removed from the refrigerator. Staff received training on 04/13/24 on the proper administering of medication, including the proper reading of labels, verifying medications and following prescriber's orders.
(DIRECTED: By 6/5/24: The administrator shall re-educate all staff persons qualified to administer medications on the home's procedures for removing medications from the home immediately upon receipt of discontinued medication orders from the prescriber to ensure only current prescription, OTC, sample and CAM for individuals living in the home are kept in the residence. Documentation of the education shall be kept in accordance with 2800.65L. 5/23/24)

Beginning on 05/20/24, The Executive Director or Nurse Supervisor will perform weekly audits of 10% of the resident population medication to include medication stored in the refrigerator for 90 days. After 90 days, each week, a random audit will occur for a resident on the North, East and MIU to ensure that no discontinued medications are being stored and that discontinued medications have been removed. (DIRECTED: Beginning on 5/30/24: The Executive Director/Nurse Supervisor shall review the medications of at least 10 residents weekly for 3 months, then monthly thereafter to ensure only current prescription, OTC, sample and CAM for individuals living in the home are present in the residence. Documentation of the weekly audits shall be kept for 2 months. 5/23/24).

Also, diabetic residents will undergo a current medication audit for current diabetic medications that are stored both in the refrigerator and otherwise. Any and all medications will be removed from the home as per the home's discontinue, removal and return policy. This policy will be reviewed and completed by no later than 05/27/24. All audits will be discussed and shared during the monthly Quality Management Meeting on 05/30/24. (DIRECTED: Documentation of the quality management review shall be kept. 5/23/24)

Proposed Overall Completion Date: 05/30/2024

Directed Completion Date: *06/05/2024*

Not Implemented (- 06/07/2024)

184a Resident meds labeled

3. Requirements

2800.
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

On 2/14/24, resident #2 was prescribed Tamsulosin 0.4 mg capsule-Take 2 capsules by mouth daily; however, on 4/24/24, resident #2's pharmacy label indicated Tamsulosin capsule 0.4 mg capsule-Take 2 capsules by mouth once daily ½ hour following the same meal each day.

184a Resident meds labeled (continued)

REPEAT VIOLATION: 1/23/2024 et al.; 8/28/2023 et al.; 8/2/2023 et al.

Plan of Correction ***Directed (- 05/23/2024)***

The prescriber's order did not state to take the medication by mouth once daily ½ hour following the same meal each day. It only stated to take the medication "once daily". The pharmacy erroneously printed a label with inaccurate directions.
Immediate Action: The pharmacy was contacted immediately provided and applied a new label to reflect the prescriber's orders.
The Executive Director or Nurse Supervisor will inspect pharmacy labels and compare them to the prescriber's orders within 24 hours whenever medications are received and compare them to the MAR to ensure accuracy and consistency. An audit of Medication comparison to Doctor orders will be completed by the Executive Director and Nurse Supervisor by no later than 06/05/24 to ensure consistency. Also, the Resident Care Director will perform these audits when the Executive Director or Nurse Supervisor are unavailable.
Training will be provided to the Med Techs to verify that the medication labels reflects the MAR. Any discrepancies will be reported immediately. This training will occur no later than 05/23/24. Documentation will be kept and any discrepancies will be corrected and discussed at the monthly Quality Management Meeting on 05/30/24. (DIRECTED: Documentation of the quality management review shall be kept. 5/23/24)

DIRECTED: Beginning on 5/30/24: The Executive Director/Nurse Supervisor shall review the medications of at least 10 residents weekly for 3 months, then monthly thereafter to ensure accurate and complete pharmacy labels are present on resident medications in accordance with 2800.184a. Documentation of the weekly audits shall be kept for 2 months. 5/23/24).

Proposed Overall Completion Date: 05/30/2024

Directed Completion Date: *06/05/2024*

Not Implemented (- 06/07/2024)

187d Follow prescriber's orders

4. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 4/1/24, resident #3 was prescribed Lispro insulin pen 100u/ml-Inject subcutaneously before meals in accordance with sliding scale coverage; however, on 4/13/24 at approximately 12:00 PM, resident #3 was administered 14 units of Novolog insulin instead of Lispro insulin.

REPEAT VIOLATION: 1/23/2024 et al.; 9/26/2023 et al.; 8/28/2023 et al.; 8/2/2023 et al.

Plan of Correction ***Directed (- 05/23/2024)***

Immediate Action: All staff trained to pass medication received training on 04/13/24 on the proper administering

187d Follow prescriber's orders (continued)

of medication, including the proper reading of labels, verifying medications and following prescriber's orders. (DIRECTED: Documentation of the education shall be kept in accordance with 2800.65L. [redacted] 5/23/24).
The Executive Director or Nurse Supervisor will perform weekly audits to include diabetic residents and ensure that correct medication, dosages and documentation are accurate. Also, diabetic residents will undergo a current medication audit for current medications. Additionally, weekly, random observations of Med Techs will be conducted to reinforce the training. Documentation will be kept.
These audits will be discussed and shared during the monthly Quality Management Meeting on 05/30/24. (DIRECTED: Documentation of the quality management review shall be kept. [redacted] 5/23/24)

DIRECTED: Beginning on 5/30/24: The Executive Director/Nurse Supervisor shall review the medications and medication administration records of at least 10 residents weekly for 3 months, then monthly thereafter to ensure the directions of the prescriber are followed. Documentation of the weekly audits shall be kept for 2 months. [redacted] 5/23/24).

Proposed Overall Completion Date: 05/30/2024

Directed Completion Date: *05/30/2024*

Not Implemented ([redacted] - 06/07/2024)

225b Assessment content

5. Requirements

2800.
225.b. The assessment must, at a minimum include the following:

1. The resident's need for assistance with ADLs and IADLs.
2. The mobility needs of the resident.
3. The ability of the resident to self-administer medication.
4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.
5. The resident's need for supplemental health care services.
6. The resident's need for special diet or meal requirements.
7. The resident's ability to safely operate key-locking devices.

Description of Violation

Resident #1's most recent assessment, dated [redacted], does not include an assessment of numerous care needs, to include bowel management, ambulating and personal hygiene. These sections of resident #1's assessment are blank.

Plan of Correction ***Directed ([redacted] - 05/23/2024)***

Resident #1 has since moved out of the community.
Immediate Action: Beginning on 05/20/24, the Executive Director and Resident Care Coordinator will audit ALL resident ASP's and update any that are found to be missing care needs to be completed and in compliance by no later than 05/31/24. The Executive Director or Resident Care Coordinator will perform an audit of new resident admissions prior to 15 days from move-in, and following the new resident admission checklist to ensure compliance. Documentation will be kept. (DIRECTED: The audits of new resident assessments shall begin on 5/27/24. [redacted] 5/23/24). New resident admissions, the process and proper paperwork will be discussed at the monthly Quality Management Meeting on 05/30/24. (DIRECTED: Documentation of the quality management review shall be kept.

225b Assessment content (continued)

[redacted] *5/23/24).*

DIRECTED: By 6/5/24: The administrator shall re-educate all staff persons responsible for completing resident assessments on the home's admission checklist and to ensure all resident assessments are completed in their entirety. Documentation of the staff education shall be kept in accordance with 2800.65L. [redacted] *5/23/24).*

Proposed Overall Completion Date: 05/30/2024

Directed Completion Date: *06/05/2024*

Not Implemented ([redacted] - 06/07/2024)

227d Support plan – med/dental

6. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Resident #1's most recent assessment, dated [redacted] *indicates several diagnoses to include Osteoarthritis, Hypertension, Alzheimer's Disease, and Major Depression; however, resident #1's most recent support plan, dated* [redacted]*, does not include the specific plan to meet each need and only indicates, "follow MD's orders as need related to diagnosis" for each of resident #1's physical and psychological diagnoses.*

Plan of Correction ***Directed ([redacted] - 05/23/2024)***

Resident #1 has since moved out of the community.
Immediate Action: Beginning on 05/20/24 the Executive Director and Resident Care Coordinator will audit ALL resident ASP's and update any to include specific plans to meet each need as identified by the MD. These audits and updates will be completed by no later than 05/31/24. The Executive Director or Resident Care Coordinator will perform an audit of new resident admissions prior to 15 days from move-in, and following the new resident admission checklist to ensure compliance. (DIRECTED: The audits of new resident support plans shall begin on 5/27/24. [redacted] *5/23/24). Documentation will be kept. New resident admissions, the process and proper paperwork will be discussed at the monthly Quality Management Meetings on 05/30/24. (DIRECTED: Documentation of the quality management review shall be kept.* [redacted] *5/23/24).*

DIRECTED: By 6/5/24: The administrator shall re-educate all staff persons responsible for completing resident support plans on the home's admission checklist and to ensure all resident support plans are completed in their entirety. Documentation of the staff education shall be kept in accordance with 2800.65L. [redacted] *5/23/24).*

Proposed Overall Completion Date: 05/30/2024

Directed Completion Date: *06/05/2024*

Not Implemented ([redacted] - 06/07/2024)