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

August 19, 2024

[redacted], ED
ANNS CHOICE INC
16000 ANN'S CHOICE WAY
WARMINSTER, PA, 18974

RE: ANN'S CHOICE
16000 ANN'S CHOICE WAY
WARMINSTER, PA, 18974
LICENSE/COC#: 14439

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/23/2024, 04/24/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ANN'S CHOICE* **License #:** *14439* **License Expiration:** *01/02/2025*

Address: *16000 ANN'S CHOICE WAY, WARMINSTER, PA 18974*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *ANNS CHOICE INC*

Address: *16000 ANN'S CHOICE WAY, WARMINSTER, PA, 18974*

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

Certificate(s) of Occupancy

Type: *Other* **Date:** *11/19/2018* **Issued By:** *warminster township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *74* **Waking Staff:** *56*

Inspection Information

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

Reason: *Renewal, 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: *98* **Residents Served:** *52*

Special Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *52*

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

Have Mobility Need: *22* **Have Physical Disability:** *2*

Inspections / Reviews

04/23/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/25/2024*

06/13/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/17/2024*

Inspections / Reviews *(continued)*

06/24/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/22/2024*

08/19/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/22/2024*

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

25a Resident - residence contract

1. 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 1's date of admission was [redacted], however resident's contract was not signed until [redacted]

Resident 2's date of admission was [redacted], however the resident's contract does not have a date, and no determination can be made of when it was signed.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by Healthcare Counselor to have Resident #2 sign contract on 5/21/2024.
2. HCC or designee will audit all AL resident contracts for compliance by 6/1/1014.
3. HCC was educated by ANHA on 4/24/2024 regarding requirement 2800.25a that prior to admission or within 24 hours a written resident-residence contract must be in place.
4. New admissions to Assisted Living residence will have their residence contracts audited weekly x12 weeks beginning the week of 5/27/2024 to ensure they are signed prior to, or within 24 hours of admission.
5. Results of audits will be presented at the monthly QAPI meetings x3 months.

Proposed Overall Completion Date: 07/22/2024

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

42b Abuse/Neglect

2. 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 4/1/2024, resident 3 pressed [redacted] call bell multiple times requesting assistance to use the bathroom throughout the night and early morning. Around 4:00 am when [redacted] pressed [redacted] call bell, staff member A, came to the resident's room and cursed at resident 3 telling resident 3, that they were ringing the call bell too much. Staff member A told the resident they would send the resident to "the 3rd floor" which is the location of the home's memory care unit. Resident 3 stated they felt horrible and felt that they could not trust anyone after the incident occurred. The resident's support plan shows that [redacted] needs total physical assistance with toileting and transferring in and out of bed. The resident is diabetic and frequently needs to urinate.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Abuse/Neglect investigation initiated immediately on 4/1/2024 and completed on [redacted] resulting in

42b Abuse/Neglect (continued)

employee termination.
2. Staff Development Coordinator (SDC) will provide abuse/neglect education to the Assisted Living staff by July 22, 2024.
3. An Audit of new and current employee education on Abuse/Neglect will be completed weekly x12 weeks, beginning on 5/27/24.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Proposed Overall Completion Date: 07/22/2024

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented (- 08/19/2024)

62 Contact list

3. Requirements

2800.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person the Administrator, maintains a list of staff members that does not include all direct care staff members, or staff members who are hired for the personal care side of the community but substitute on the assisted living side.

Plan of Correction ***Accept (- 06/24/2024)***

1. Immediate action was taken to update contact list to include the name, address and telephone numbers of direct care staff persons for Assisted Living, Personal Care residence and Nursing supervisors.
2. New employees to the Assisted Living, Personal Care residence and nursing supervisors to be added to the Contact list when their orientation is completed.
3. An Audit of new employees hired for the Assisted Living, Personal Care residence and Nursing supervisors will be completed weekly x12 weeks beginning the week of 5/27/24 to ensure their contact information is appropriately updated on the Contact list.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Proposed Overall Completion Date: 07/22/2024

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented (- 08/19/2024)

65h 16 hrs annual training

4. Requirements

2800.
65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Direct care staff person C received only 8.5

65h 16 hrs annual training (continued)

hours of annual training relating to [redacted] job duties during training year 1/1/2023 to 12/31/2023, and only 9 hours from 1/1/2022 to 12/31/2022.

Direct care staff person D received only 6.5 hours of annual training relating to [redacted] job duties during training year 1/1/2023 to 12/31/2023

Direct care staff person E received only 11.5 hours of annual training relating to [redacted] job duties during training year 1/1/2023 to 12/31/2023, and only 5.5 hours from 1/1/2022 to 12/31/2022.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by SDC or designee to schedule the completion of the following education by June 15, 2024:
Direct care staff person C will complete 7.5 hours of annual training.
Direct care staff person D will complete 9.5 hours of annual training.
Direct care staff person E will complete 4.5 hours of annual training.
This education will provide each direct care staff person with a total of 16 hours of annual training related to their job duties.
2. SDC or designee will Audit Learning Transcripts of current direct care staff to confirm their training records identify at least 16 hours of annual training related to their job duties.
3. ALM or designee will randomly audit 10% of their direct care staff training records weekly beginning the week of 5/27/24 to confirm education records include required education.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

69 Dementia training

5. 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

New hire training only includes a total of 1 hour and 15 minutes of dementia training within the first 30 days of hire.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by SDC, or designee to review current new hire training plan and amend to include at least 4 hours of dementia-specific training within 30 days of hire by the next orientation class on June 10, 2024.
2. ALM or designee will audit new hire learning transcripts weekly x12 weeks beginning the week of 5/27/2024 to ensure compliance with at least 4 hours of dementia-specific training within 30 days of hire.
3. Results of audits will be presented at the monthly QAPI meetings x3 months.

69 Dementia training *(continued)*

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

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

Staff person F, date of hire [redacted] did not receive 2 hours of dementia-specific training during training year 1/1/2023 to 12/31/2023.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by SDC to schedule 2 hours of dementia-specific training for staff person F by June 15, 2024.
2. SDC, or designee will review annual training plan and amend to include 2 hours of dementia-specific training annually.
3. ALM or designee will audit 10% of staff learning transcripts weekly x12 weeks beginning the week of 5/27/2024 to ensure compliance with at least 2 hours of dementia-specific training annually.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Proposed Overall Completion Date: 07/22/2024

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

81b Resident equip – good repair

7. Requirements

2800.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident 4's bedside mobility device position on the left side of [redacted] bed closest to the wall, was not securely attached to the bed frame, and when pulled the entire mattress moved with the device.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by ALM to remove bedside mobility device from Resident #4's bed on 4/26/2024.
2. An Audit of Assisted Living bedside mobility devices will be completed to confirm that they are securely attached to the bed frame by June 15, 2024.
3. ALM or [redacted] designee will audit 20% of bedside mobility devices weekly x12 weeks beginning the week of May 27, 2024 to ensure devices are securely attached.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

81b Resident equip – good repair *(continued)*

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

85a Sanitary conditions

8. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/23/2024, at 11:42 am, there was an orange rust color puddle of liquid seeping out of the bottom of the refrigerator in the 1st floor serving kitchen.

On 4/23/2024, at 11:46 am, there was an open glass condiment bottle of red wine vinegar on the dry storage shelf by the door that had numerous fruit flies floating in it.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by housekeeping staff to clean rust color puddle from the floor on 4/24/24.
2. New gasket installed to prevent leaking; awaiting delivery of new refrigerator system.
3. All condiments will be stored properly and follow food safety and sanitation guidelines.
4. Dining manager, or designee will complete weekly audits x12 weeks beginning the week of 5/27/2024 of the pantry shelf to ensure sanitary conditions are maintained.
5. Results of audits will be presented at the month QAPI meeting x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

85b Infestation

9. Requirements

2800.
85.b. There may be no evidence of infestation of insects or rodents in the residence.

Description of Violation

On 4/23/24, at approximately 11:45 am, numerous fruit flies were observed flying around the first floor serving kitchen. When serving staff was questioned, they reported that it was a normal occurrence to have fruit flies in the kitchen when the weather changes.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by housekeeping staff to clean floor drains on 4/24/2024.
2. Pest control continues weekly.
3. Dining manager, or designee will complete weekly audits x12 weeks beginning the week of 5/27/2024 of the first floor serving kitchen to ensure there is no evidence of infestation of insects or rodents in the residence.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

85b Infestation (continued)

Proposed Overall Completion Date: 07/22/2024

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

103c Food protected

10. Requirements

2800.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 4/23/24, there was a Sara Lee pound cake in the dessert refrigerator that was uncovered and unsealed.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by Dining Services Associate to discard cake on 4/24/2024.
2. Dining manager, or designee with educate dining staff on the procedure of dating food items with an education completion date of 6/28/2024.
3. Dining manager, or designee will complete weekly audits beginning the week of 5/27/2024 of the dessert refrigerator items to ensure food is protected from contamination while being stored, prepared, transported and served x12 weeks.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

103f Fridge/Freezer Temps

11. Requirements

2800.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 4/23/2024, at 11:40 am, the temperature in the 1st floor ice cream freezer was 10 degrees Fahrenheit and at 11:49 am it was 20 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by Dining Services manager to monitor temperature of freezer 3x daily.
2. April 25, 2024 to May 22, 2024 daily logs were reviewed and recorded temperatures of the freezer were at or below 0° Fahrenheit.
3. Daily temperature logs of the 1st floor ice cream freezer will be completed by Dining staff.
4. Freezer to be replaced in May 2024.
5. Dining manager, or designee will complete weekly audits x12 weeks beginning the week of 5/27/2024 of the ice cream freezer temperatures to ensure frozen food is kept at or below 0° Fahrenheit.

103f Fridge/Freezer Temps (continued)

6. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

103i Outdated food

12. Requirements

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an undated Sara Lee pound cake in the dessert refrigerator.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by Dining Services Associate to discard cake on 4/24/2024.
2. Dining manager, or designee with educate dining staff on the procedure of dating food items with an education completion date of 6/28/2024
3. Dining manager, or designee will complete weekly audits of dessert refrigerator items to ensure outdated or spoiled food or dented cans are not to be used x12 weeks beginning the week of 5/27/2024.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

132b Safety inspection/fire drill

13. 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 last fire safety inspection observed by a fire safety expert was conducted on 11/27/2023. The previous fire safety inspection was conducted on 11/11/2022, over 380 days prior.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually.
2. Documentation of the fire drill and inspection will be maintained by Assisted Living Administrator or designee.
3. The Assisted Living Administrator has been assigned the task to contact Fire Safety Inspector timely to coordinate annual fire drill and fire safety inspection completion by the annual due date in 2024.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

132f Alternate exit routes

14. Requirements

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

Description of Violation

The #3 stair well was used during the fire drills held from 7/25/2023 to 9/22/2023.

Plan of Correction ***Accept (- 06/12/2024)***

1. Immediate action was taken by the ANHA to schedule Fire Drill on 4/29/2024 utilizing Stair #1 as exit route.
2. ALM, or designee will monitor the plan of the origin of the fire drill to ensure that alternate exit routes will be used during drills.
3. Monthly fire drill documentation will be audited to ensure exit routes are alternated.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented (- 08/19/2024)

132h Designated meeting place

15. 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

During fire drills, residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. Based on resident and staff interviews, residents came to the door to be counted and then remained in their rooms.

Plan of Correction ***Accept (- 06/24/2024)***

1. Immediate action taken by SDC and ALM to schedule education for residents and staff as to the designated meeting place and fire-safe areas to evacuate to during a fire drill.
2. ALM or designee to monitor fire drill documentation to ensure compliance with regulation.
3. ALM will review fire drill education of staff and residents weekly beginning the week of 5/27/2024 with a completion date of education on 7/22/2024
3. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented (- 08/19/2024)

141b1 Annual medical evaluation

16. Requirements

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

Description of Violation

Resident 2's most recent medical evaluation was completed on

141b1 Annual medical evaluation (continued)

. The resident's previous medical evaluation was completed on [redacted]

Resident 5's most recent medical evaluation was completed on [redacted] *The resident's previous medical evaluation was completed on* [redacted]

Repeat Violation date 8/3/21 and 10/31/22 et al.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by ALM to audit annual medical evaluations of all current Assisted Living Residents.
2. ALM, or designee will ensure ADME forms are current, completed in full with supporting documentation attached, and that resident's chart contains two consecutive years of ADMEs if applicable.
3. ALM or designee will audit ADME's weekly x12 weeks beginning the week of 5/27/2024 to ensure compliance.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

182c Medication administration

17. Requirements

2800.
182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2800.187 (relating to medication records).

Description of Violation

Resident 3 is prescribed Lantus U-100 unit/ML subcutaneous solution which was administered by staff person [redacted] *a nurse, on 4/11/2024, 4/12/24 and 4/15/2024. However, resident's 3 medication administration record does not include the name and initials of staff person* [redacted] *Resident 3's record shows initials of direct care staff member H, who did not administer this medication and is not trained to administer insulin injections.*

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by SDC and Wellness manager to educate and review medication administration requirements for staff persons [redacted] *and H on 4/26/24.*
2. Wellness Manager or designee will audit current residents with insulin orders to ensure proper staff signatures on the MAR by 6/15/2024.
3. SDC, or designee will educate licensed staff and CAM's on proper signature on the MAR with a completion date of education on 7/22/2024.
4. Wellness Manager or designee will audit 10% of current residents with insulin orders weekly x12 weeks beginning the week of 5/27/2024 to ensure compliance with proper signatures.
5. Results of audits will be presented at the monthly QAPI meetings x3 months.

182c Medication administration (continued)

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

183a Original containers / no pre-pour / injections

18. Requirements

2800.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 03/30/2024, 2 tablets of Oxycodone 5 mg for resident 6 were popped out of the blister pack and given to resident's family to take home over night. This medication was not scheduled for administration until the evening of 03/30/24 and morning of 03/31/24.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action taken by SDC, or designee to educate licensed staff and CAMS on the Leave of Absence (LOA) policy including that medications shall be kept in their original labeled container and may not be removed more than 2 hours in advance of the scheduled administration.
2. Wellness manger, or designee will audit medication provisions for LOA's weekly x12 weeks beginning the week of 5/27/2024
3. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

183e Storing Medications

19. Requirements

2800.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident's 3's locked medication cabinet in [redacted] room had pills and broken pieces of pills strewn about the bottom including a whole blueish oblong pill, and multiple pieces of both red and white pills. There was also a brown round tablet sitting on the counter outside the cabinet.
Resident 3's Simethicone 80 mg tab blister pack and 2 Levothyroxine 88 mcg blister packs had multiple broken seals.
Resident 6's blister pack of Oxycodone 5 mg twice a day had broken seals and was taped over.
Resident 7's PRN of Oxycodone 5 mg blister pack had broken seals and was taped over in the back.

183e Storing Medications (continued)

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by Wellness manager, or designee to audit Assisted Living medication and narcotic cabinets to ensure medications are stored under proper conditions.
2. New narcotic boxes have been ordered and installed in the Assisted Living area.
3. Random audits will be completed by Wellness Manager, or designee weekly on 10% of the Assisted Living medication and narcotic cabinets beginning the week of 5/27/2024 to ensure medications are stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

184a Resident meds labeled

20. 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

The pharmacy label for resident 8's Levothyroxine 100 mg states take 1 tablet by mouth in the morning on an empty stomach, while resident 8's medication administration record reads take one tablet every two days.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by Wellness manager to place a change in direction sticker on resident's #8 medication to match MAR on 4/24/2024.
2. Random audits will be completed by Wellness Manager, or designee weekly on 10% of Assisted living residents x 12 weeks beginning the week of 5/27/2024 to ensure prescription labels include required information and that the prescription label matches the MAR.
3. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

185a Storage procedures

21. Requirements

185a Storage procedures *(continued)*

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

On 4/24/2024, at 12:09 pm, resident 3's glucometer read 4/24/2024 11:22 am.

Resident 9's blister pack of oxycodone 5 mg tab is missing one pill. The narcotic log does not indicate if this pill was administered or wasted, or what date it was removed.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by Wellness manager on 4/24/2024 upon identification, the time on resident #3's glucometer was reset to reflect the correct time.
2. Licensed staff will be educated on reading and resetting glucometer time to ensure accuracy with an education completion date of 7/22/2024.
3. Investigation into resident #9 blister pack revealed documentation of pill being wasted due to broken seal of medication packaging.
4. Wellness manager, or designee will audit 10% of residents with glucometers weekly beginning the week of 5/27/2024 to ensure accurate time on the glucometer. Wellness manger, or designee will audit 10% of narcotic logs weekly beginning the week of 5/27/2024 to ensure accuracy of logs while verifying medications in narcotic box are being stored in compliance.
5. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

187a Medication record

22. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 3 is prescribed Lantus U-100 unit/ML subcutaneous solution which was administered by staff person [redacted] a

187a Medication record (continued)

nurse, on 4/11/2024, 4/12/24 and 4/15/2024. However, resident's 3 medication administration record does not include the name and initials of staff person [redacted] Resident 3's record shows initials of direct care staff member H, who did not administer this medication and is not trained to administer insulin injections.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by SDC and Wellness manger to provide education of staff persons [redacted] and H on Medication Records on 4/26/2024.
2. Wellness Manager or designee will audit current residents with insulin orders to ensure proper staff signatures on the MAR by 6/15/2024.
3. SDC, or designee will educate licensed staff and CAM's on proper signature on the MAR with a completion date of education of 7/22/2024.
4. Wellness Manager or designee will audit 10% of current residents with insulin orders weekly x12 weeks beginning the week of 5/27/2024 to ensure compliance with proper signatures.
5. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

187b Date/time of med admin

23. 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

Resident 10 is prescribed pregabalin 25 mg twice a day. Resident 10's narcotic log was not signed out as administered on 4/2/2024 at 8pm, 4/8/2024 at 8pm, or 4/9/2024 at 8pm but was initialed as administered in the medication administration record.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by SDC and Wellness manger to provide employee education on Date/time of medication administration requirement.
2. SDC, or designee will educate CAM's on proper signature on the narcotic log and the MAR with an education completion date of 7/22/2024.
3. Wellness Manager or designee will audit 10% of current residents with orders for narcotics weekly x12 weeks beginning the week of 5/27/2024 to ensure compliance with proper signatures.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

187d Follow prescriber's orders

24. Requirements

2800.

187d Follow prescriber's orders *(continued)*

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

Description of Violation

Resident 10 is prescribed pregabalin 25 mg twice a day. However, resident 10 did not receive this medication on 4/2/2024 at 8pm, 4/8/2024 at 8pm, and 4/9/2024 at 8pm because it was not signed out on the narcotic log.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action was taken by SDC and Wellness manger to provide employee education on following prescriber's orders.
2. SDC, or designee will educate CAM's on proper signature on the narcotic log and the MAR with an education completion date of 7/22/2024.
3. Wellness Manager or designee will audit 10% of current residents with orders for narcotics weekly x12 weeks beginning the week of 5/27/2024 to ensure compliance with proper signatures.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

190a Completion of course–meds

25. 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 member D has not completed the Department-approved medication administration course, as there is no record of a medication administration record review for them on 11/29/2022 and 11/17/2023. Staff member D administered medications to residents on 4/6/2024, 4/7/2024, 4/11/2024, and 4/18/2024.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action taken by SDC to schedule staff member E to complete requirements for Department-approved medications administration re-certification by June 15, 2024.
2. SDC, or designee will audit 10% of staff members on AL weekly beginning the week of 5/27/2024 to ensure staff have completed the required medication administration education.
3. The Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

203 Bedside rails

26. Requirements

2800.
203. Bedside Rails

203 Bedside rails *(continued)*

a. Bedside rails may not be used unless the resident can raise and lower the rails on his own. Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.
b. Half-length rails are permitted only if the following conditions are met:
    1. The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.
    2. The residence has attempted to use less restrictive alternatives.
    3. The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.

Description of Violation

Resident 11 has a half length adjustable bed rails on each side of [redacted] bed. When interviewed, the resident stated they cannot lift or lower the bed rails independently.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

1. Immediate action taken by ALM to initiate bedside mobility device reassessment for Resident 11.
2. ALM, Wellness manager, or designee will complete audit of bed mobility devices for Assisted Living residents to ensure compliance by 6/19/2024.
3. ALM, Wellness manger, or designee will audit 10% of bedside mobility devices weekly x 12 weeks beginning the week of 5/27/2024 to verify bedside mobility device is in compliance.
4. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented ([redacted] - 08/19/2024)

227d Support plan – med/dental

27. 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

The assessment for resident 4, dated [redacted] does not indicate the resident has a need for bedside mobility. The resident's support plan, dated [redacted], indicates the resident has a quarter rail on the left side of [redacted] bed, however that was not the device attached to the resident's bed. The resident has a detachable bedside mobility device. The resident's support plan does not include:
the specific need for the device, the intended use, any risks associated with the device, the resident's ability to use the device safely for the intended purpose, Identification of the specific device to be used, or If a cover is required to meet FDA guidelines.

The assessment for resident 11, dated [redacted], indicates the resident has a need for assistance with repositioning in bed. The resident's support plan, dated [redacted] indicates the resident has a U-bar on the left and right side of the bed, however those were not the devices attached to the resident's bed. The resident's bed had an adjustable bed rail

227d Support plan – med/dental (continued)

on each side. The resident's support plan does not include:
the specific need for the device, the intended use, any risks associated with the device, the resident's ability to use the device safely for the intended purpose, Identification of the specific device to be used, or If a cover is required to meet FDA guidelines.

Plan of Correction ***Accept (- 06/24/2024)***

1. Immediate action was taken by ALM to update Service plans for resident #4 and resident #11.
2. ALM, Wellness manager, or designee will audit service plans by 6/19/2024 of residents in Assisted Living that utilize a bedside mobility device and update appropriately with a) the specific need for the device, b) the intended use of the device, c) any risks associated with the device, d) the residents' ability to use the device safely for the intended purpose, e) identification of the specific device to be used and f) if a cover is required to meet FDA guidelines.
3. ALM, Wellness manger, or designee will audit 10% of Service Plans of residents with a BSMD weekly x 12 weeks beginning the week of 5/27/2024 and verify bedside mobility device documentation is accurate and complete.
5. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented (- 08/19/2024)

227g Support plan - signatures

28. 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 2 participated in the development of [redacted] support plan on [redacted]. However, the home could not provide a signature page for the support plan.

Resident 4 participated in the development of [redacted] support plan on [redacted] However, the home could not provide a signature page for the support plan.

Resident 5 participated in the development of [redacted] support plan on [redacted]. However, the home could not provide a signature page for the support plan.

Resident 12 participated in the development of [redacted] support plan on [redacted] However, the home could not provide a signature page for the support plan.

Repeat Violation: 7/22/21, 5/4/22 and 10/31/22 et al.

227g Support plan - signatures (continued)

Plan of Correction ***Accept (- 06/24/2024)***

1. Resident #2 has a current Support Plan signature. With next Resident Service Plan review, a signature will be obtained from resident.
2. Resident # 4's Support plan dated ; service plan reviewed and signature updated by resident on 5/17/2024.
3. Resident #5 has a current Support Plan signature. Resident has been discharged from the center.
4. Resident #12 has a current Support Plan signature. With next Resident Service Plan review, a signature will be obtained from resident.
5. ALM or designee will audit support plan signatures weekly x12 weeks beginning the week of 5/27/2024.
6. Results of audits will be presented at the monthly QAPI meetings x3 months.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented (- 08/19/2024)