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

September 17, 2024

[redacted], PRESIDENT
MDT ALF 1, LLC
[redacted]

RE: LEGEND AT SILVER CREEK
425 LAMBS GAP ROAD
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33925

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/30/2024, 05/01/2024 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: *LEGEND AT SILVER CREEK* **License #**: *33925* **License Expiration**: *10/04/2024*

Address: *425 LAMBS GAP ROAD, MECHANICSBURG, PA 17050*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MDT ALF 1, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *07/14/2023* **Issued By**: *Hampden Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *114* **Waking Staff**: *86*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *05/01/2024*

Inspection Dates and Department Representative

04/30/2024 - On-Site: [redacted]

05/01/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *108* **Residents Served**: *89*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *24* **Residents Served**: *18*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *88*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *25* **Have Physical Disability**: *1*

Inspections / Reviews

04/30/2024 - Partial

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

05/20/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/07/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/27/2024*

Inspections / Reviews *(continued)*

05/31/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/07/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/07/2024*

09/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/07/2024*

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

57c - 2 Hours/Day

1. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 4/19/24, there were 89 residents in the home including 25 with mobility needs, requiring a total minimum of 114 hours of direct care services. On this date, only 109.5 hours of direct care staffing was provided.

On 4/21/24, there were 89 residents in the home including 25 with mobility needs, requiring a total minimum of 114 hours of direct care services. On this date, only 86.5 hours of direct care staffing was provided.

On 4/27/24, there were 89 residents in the home including 25 with mobility needs, requiring a total minimum of 114 hours of direct care services. On this date, only 71 hours of direct care staffing was provided.

Plan of Correction ***Accept ([redacted] - 05/30/2024)***

With Respect to the specific deficiency cited:

The home failed to schedule and provide adequate staffing.

With Respect to Systemic Measures that have been put into place to address the stated concern:

To prevent recurrence, on 5/2/24, The Regional Director of Operations provided the Administrator with a labor calculator to support staffing needs planning. The labor calculator ensures that each resident with a mobility concern receives two hours of personal care services daily. Beginning 5/9/24, the home has collaborated with various agencies to ensure adequate staff levels. Furthermore, the home office provides support through scheduling interviews and hiring assistance.

The Administrator/Healthcare Director will ensure direct care hours will meet the minimum requirements according to mobility and care needs to meet the minimum standard. A monthly schedule will be posted in advance, and the Administrator/Healthcare Director will calculate hours daily and ongoing to ensure the home meets the needs of the residents beginning on 5/20/24; the schedule will be modified as needed based on the staffing needs of the home ensuring that the necessary adjustments are made promptly.

With Respect to How the Plan of Corrective Measures will be Monitored:

Compliance checks will be conducted twice quarterly as part of our regular Quality Assurance meetings. This ensures that we consistently monitor the situation and make any necessary adjustments. The information from these checks will be retained accordingly for future reference.

Licensee's Proposed Overall Completion Date: *05/27/2024*

Implemented ([redacted] - 08/23/2024)

57d - Waking Hours

2. Requirements

2600.

57d - Waking Hours *(continued)*

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 4/19/24, a total of 114 hours of direct care was required. However, only 82 of the required hours, or 72 percent were provided during waking hours.

On 4/21/24, a total of 114 hours of direct care was required. However, only 61 of the required hours, or 53.5 percent, were provided during waking hours.

On 4/27/24, a total of 114 hours of direct care was required. However, only 71 of the required hours, or 62 percent, were provided during waking hours.

Plan of Correction ***Accept ([redacted] - 05/30/2024)***

With Respect to the specific deficiency cited:

The home failed to schedule and provide adequate staffing.

With Respect to Systemic Measures that have been put into place to address the stated concern:

To prevent recurrence, on 5/2/24, The Regional Director of Operations provided the Administrator with a labor calculator to support staffing needs planning. The labor calculator ensures that each resident with a mobility concern receives two hours of personal care services daily. Beginning 5/9/24, the home has collaborated with various agencies to ensure adequate staff levels. Furthermore, the home office provides support through scheduling interviews and hiring assistance.

The Administrator/Healthcare Director will ensure direct care hours will meet the minimum requirements according to mobility and care needs to meet the minimum standard. A monthly schedule will be posted in advance, and the Administrator/Healthcare Director will calculate hours daily and ongoing to ensure the home meets the needs of the residents beginning on 5/20/24; the schedule will be modified as needed based on the staffing needs of the home ensuring that the necessary adjustments are made promptly.

With Respect to How the Plan of Corrective Measures will be Monitored:

Compliance checks will be conducted twice quarterly as part of our regular Quality Assurance meetings. This ensures that we consistently monitor the situation and make any necessary adjustments. The information from these checks will be retained accordingly for future reference.

Licensee's Proposed Overall Completion Date: *05/27/2024*

Implemented ([redacted] - 08/23/2024)

183b - Meds and Syringes Locked

3. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

183b - Meds and Syringes Locked *(continued)*

Description of Violation

On 4/30/24 at 10:00 AM, there was a white pill labeled 210 observed on the floor of the Reflections dining room.

On 5/1/24 from 11:19 to 11:22 AM, the 300 hallway medication cart was unlocked, unattended, and accessible in the Reflections secured dementia care unit (SDCU).

Plan of Correction ***Accept ([redacted] - 05/30/2024)***

With Respect to the specific deficiency cited:

The home failed to recognize the pill on the dining room floor and did not note that the medication cart locking mechanism was not engaged.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Corrected on site at the time of inspection. According to policy, the Assistant Healthcare Director destroyed and discarded the medication found on the memory care dining room floor.

The pharmacy provider responded swiftly, arriving at the home within fifteen minutes of a call regarding the locking mechanism. It was discovered that the Maintenance Director had replaced each medication cart's batteries the evening prior and failed to notice the battery door was not secure, thus not engaging the locking mechanism. In response, the Administrator conducted a comprehensive retraining session on Regulation 183, Meds and Syringes Locked, for the Assistant Health Care Director, Maintenance Director, and Med Techs on 5/1/24, ensuring the importance of always ensuring the locks are engaged.

The Maintenance Director will conduct a monthly audit beginning 5/15/24, and the findings will be discussed at the monthly Quality Assurance meeting.

With Respect to How the Plan of Corrective Measures will be Monitored:

To prevent any reoccurrence, the Assistant Health Care Director, Maintenance Director, and Med techs are committed to immediately reporting any further locking mechanism issues to the pharmacy and securing the medication carts in a locked medication room.

Licensee's Proposed Overall Completion Date: *05/27/2024*

Implemented ([redacted] - 08/23/2024)

183d - Prescription Current

4. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

A bottle of Gabapentin 300 mg tablets belonging to Resident 1 was found in the 200-hallway medication cart. There is no current order for this medication at this dosage.

Plan of Correction ***Accept ([redacted] - 05/30/2024)***

With Respect to the specific deficiency cited:

183d - Prescription Current (continued)

The violation occurred due to the lack of quality assurance by the Healthcare Director/Designee.

With Respect to Systemic Measures that have been put into place to address the stated concern:

The medications were promptly corrected at the time of inspection by the Med Tech, ensuring immediate rectification, and were then removed and properly discarded, demonstrating our commitment to maintaining high standards.

On 5/2/24, the Regional Healthcare Director conducted a comprehensive retraining session for the Assistant Healthcare Director and Med Techs on Regulation 183d, Prescription Current. This training, which included the process for staff to manage physicians' orders immediately upon receipt and to retrieve items from the medication cart that are discontinued following the prescriber's direction, was designed to ensure such violations do not recur. Wellness Center staff will now verify all new orders within 24 hours, further strengthening our compliance measures.

With Respect to How the Plan of Corrective Measures will be Monitored:

Beginning 5/15/24 The Healthcare Director/Designee will complete monthly medication cart audits to confirm the supply aligns with current orders for each resident. The Administrator will monitor for ongoing compliance. Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Administrator will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *05/27/2024*

Implemented ([redacted] - 08/23/2024)

183e - Storing Medications

5. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 4/30/24, the blister card for Resident 2's Caltrate 600+D had a torn backing exposing one of the tablets.

Plan of Correction ***Accept ([redacted] - 05/20/2024)***

With Respect to the specific deficiency cited:

The violation was incurred due to the fragility of the foil lined blister package and snugly fitting blister card friction in storage likely causing the tear.

With Respect to Systemic Measures that have been put into place to address the stated concern:

The findings were corrected onsite at time of inspection, blister packs containing pills that were taped shut/contained hole were removed and wasted according to the handling policy by the Assistant Health Care Director.

183e - Storing Medications (continued)

The Regional Healthcare Director educated med techs/nurses as to the proper protocol on 5/9/24. Med techs/nurses in serviced that while administration of medication is conducted, they will ensure that blister packs are intact with no tampering to seal. In the event a blister pack is found to have a torn seal they will immediately contact the pharmacy for a replacement.

With Respect to How the Plan of Corrective Measures will be Monitored:

Med cart audit completed 5/15/24 by the Regional Director of Operations and Assistant Healthcare Director. Healthcare Director/Assistant Healthcare Director will conduct monthly med cart audits utilizing physician order statements. Beginning 5/2/24 the Healthcare Director/Assistant Healthcare Director and Administrator will monitor for ongoing compliance. Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Administrator will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented ([redacted] - 09/17/2024)

183f - Discontinued Medications

6. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

The following medications were observed in the waste can attached to the 200-hallway medication cart. Disposing of medications in the trash is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

A strip of prepackaged medications for Resident 3 including:
- Risperidone 0.5 mg tablet
- Acetaminophen tablet
- Melatonin 3 mg tablet
- Mirtazapine 15 mg tablet
- Bupropion HCL SR 100 mg tablet

A blister card with a crushed 250 mg cranberry tablet for Resident 4

Three bottles of eyedrops in prescription bottles for Resident 5 including:
- Refresh Tears 0.5%
- Timolol 0.5%
- Dorzolamide Timolol

Plan of Correction ***Accept ([redacted] - 05/20/2024)***

With Respect to the specific deficiency cited:

183f - Discontinued Medications (continued)

The violation occurred due to med-techs failure to follow proper protocol for disposal of medications.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Corrected onsite at time of inspection. All discarded medications to include those for Residents #3, #4, & #5 were properly disposed of in accordance with policy and according to the Department of Environmental Protection and Federal and State regulation. The Regional Healthcare Director educated med techs/nurses as to the proper protocol on 5/9/24.

With Respect to How the Plan of Corrective Measures will be Monitored:

Beginning 5/2/24, Healthcare Director/Assistant Healthcare Director will monitor for ongoing compliance. Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Administrator will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented ([redacted] - 08/23/2024)

184a - Resident's Meds Labeled

7. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy labels for the following medications belonging to Resident 1 had the incorrect dose listed:

- Famotodine Tabs 20 mg, label states take 1 tablet before meals and at bedtime. The order states take 1 tablet by mouth daily.
- Midodrine HCL Tabs 5 mg, label states take 1 tablet before meals and at bedtime. The order states take 1 tablet by mouth twice daily.
- Fluticasone Prop 50 mcg, 2 sprays in each nostril twice daily. The order states 2 sprays in each nostril in the morning.

Plan of Correction ***Accept ([redacted] - 05/20/2024)***

With Respect to the specific deficiency cited:

The violation occurred due to the lack of quality assurance by the Healthcare Director/Assistant Healthcare Director/Designee.

With Respect to Systemic Measures that have been put into place to address the stated concern:

The medications label was corrected at time of inspection. The med tech and nurses were re-trained on regulation 2600.184(b) on 5/9/24 by the Regional Healthcare Director. All medications must include a proper label with consistency as orders change.

With Respect to How the Plan of Corrective Measures will be Monitored:

184a - Resident's Meds Labeled (continued)

Beginning 5/13/24, The Healthcare Director/Assistant Healthcare Director/Designee will perform an audit upon receipt of a physician's order and subsequent receipt of medication from the pharmacy to ensure accuracy. The Healthcare Director/Assistant Healthcare Director will immediately contact the pharmacy regarding any discrepancy, and they will ensure the order has been received and is accurate prior to placement in the med cart. The Healthcare Director/Assistant Healthcare Director will monitor for ongoing compliance through a monthly med cart audit.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Administrator will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented ([redacted] - 08/23/2024)

184b - Labeling OTC/CAM

8. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 4/30/24, the following medications belonging to Resident 1 were not labeled with the resident's name:
- Ferosulfate 65 mg tablets
- Vitamin D3 25 mcg tablets
- Vitamin B-1 100 mg tablets

Plan of Correction ***Accept ([redacted] - 05/20/2024)***

With Respect to the specific deficiency cited:

The violation occurred due to the lack of quality assurance by the Healthcare Director/Designee.

With Respect to Systemic Measures that have been put into place to address the stated concern:

The medications label was corrected at time of inspection. The med tech and nurses were re-trained on regulation 2600.184(b) on 5/9/24 by the Regional Healthcare Director. All over the counter and CAMS will be labeled with the resident name immediately upon receipt.

With Respect to How the Plan of Corrective Measures will be Monitored:

Beginning 5/13/24, The Healthcare Director/Assistant Healthcare Director/Designee will perform a monthly med cart audit upon receipt of a physician's order and subsequent receipt of medication from the pharmacy to ensure accuracy. The Healthcare Director/Assistant Healthcare Director will immediately contact the pharmacy regarding any discrepancy, and they will ensure the order has been received and is accurate prior to placement in the med cart.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the

184b - Labeling OTC/CAM (continued)

Administrator will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented ([redacted] - 08/23/2024)

185a - Implement Storage Procedures

9. Requirements

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

Description of Violation

Resident 1 was prescribed Calcium Carb Reg 500 mg, chew one tablet in the morning and one tablet before bedtime. This medication was not available in the home from 3/20/24 at 8:00 PM through 3/25/24 at 8:00 AM.

Repeated Violation - 1/6/24

Plan of Correction ***Accept ([redacted] - 05/20/2024)***

With Respect to the specific deficiency cited:

The violation occurred due to the lack of quality assurance by the Healthcare Director/Assistant Healthcare Director/Designee.

With Respect to Systemic Measures that have been put into place to address the stated concern:

The medication supply was re-ordered/corrected at the time of inspection. Beginning 5/13/24, The Healthcare Director/Assistant Healthcare Director/Designee will perform an audit upon receipt of a physician's order and subsequent receipt of medication from the pharmacy to ensure accuracy. The Healthcare Director/Assistant Healthcare Director will immediately contact the pharmacy regarding any discrepancy and will ensure the order has been received and is in supply and present and accurate before placement in the med cart.

With Respect to How the Plan of Corrective Measures will be Monitored:

Beginning on 5/13/24 the Healthcare Director/Assistant Healthcare Director will monitor for ongoing compliance through a monthly med cart audit. Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Administrator will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented ([redacted] - 09/17/2024)

10. Requirements

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

185a - Implement Storage Procedures *(continued)*

Description of Violation

On 4/30/24, the locks on the 100 and 300-hallway medication carts were not operable, permitting anyone with access to the carts to have access to the medications stored inside. At 11:58 AM, the licensing representative found the keys for the controlled substances inside of one of the unlocked carts and was able to access controlled substances stored on both carts including Resident 6's Tramadol and Resident 7's Ativan.

Repeated Violation - 1/6/24

Plan of Correction ***Accept ([redacted] - 05/20/2024)***

With Respect to the specific deficiency cited:

On 5/1/24 from 11:19 to 11:22 AM, the 100 and 300 hallway medication carts were unknowingly unlocked and unattended/accessible. The home failed to note that the medication cart locking mechanism was not engaged.

With Respect to Systemic Measures that have been put into place to address the stated concern:

The pharmacy provider arrived at the home within fifteen minutes of a call regarding the locking mechanism. It was determined that the Maintenance Director had replaced each of the medication carts batteries the evening prior and failed to recognize the battery door was not secure, therefore not engaging the locking mechanism. The Assistant Health Care Director, Maintenance Director and Med Techs were educated by the Residence Director regarding the importance of ensuring that the locks are engaged at all times. Education completed with at time of inspection 5/1/24.

With Respect to How the Plan of Corrective Measures will be Monitored:

Beginning 5/1/24 to prevent reoccurrence, the Assistant Health Care Director, Maintenance Director and Med techs will immediately report any further locking mechanism issues to the pharmacy and secure the medication carts in a locked medication room.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented ([redacted] - 09/17/2024)

187a - Medication Record

11. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Multiple resident medication administration records (MARs) do not include a diagnosis or purpose for prescribed medications including:

- Resident 1's Clopidogrel 75 mg tablets, Famotodine 20 mg tablets, and Midodrine HCL 5 mg tablets
- Resident 2's Atorvastatin 40 mg tablets, Basaglar 100 unit/ML Kwikpen, and Benazepril HCL 40 mg tablets

187a - Medication Record (continued)

- Resident 8's Docus Sod S/G 100 mg, Fenofibrate 160 mg tablet, and Mycophenolate 500 mg tablets
- Resident 9's Bumetadine 0.5 mg tablet , Farxiga 10 mg tablet, and Sodium Chloride 1 gm tablets

Plan of Correction ***Accept (- 05/20/2024)***

With Respect to the specific deficiency cited:

The pharmacy failed to perform quality checks to be sure all required information was present on the medication and MAR label prior to dispensing the supply to the home.

With Respect to Systemic Measures that have been put into place to address the stated concern:

On 5/1/24 the Healthcare Director/Assistant Healthcare Director reviewed all medication labels and MARS and contacted the pharmacy to request they must include the diagnosis for each individual medication listed. On the same date the Healthcare Director/Assistant Healthcare Director were able to contact the pharmacy provider who immediately began corrections to the MAR label and added any diagnosis previously omitted.

With Respect to How the Plan of Corrective Measures will be Monitored:

The Healthcare Director/Assistant Healthcare Director and/or designee will complete verification of the medication and MAR upon receipt from the pharmacy to be sure the diagnosis are present on the MAR.

Beginning 5/15/24 the Healthcare Director/Assistant Healthcare Director will monitor for ongoing compliance through a monthly med cart audit. Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Administrator will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented (- 09/17/2024)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident 5 is prescribed Dorzolamide-Timolol eye drops. This medication was not administered on 4/30/24 at 8:00 AM because Staff B stated that the medication had been disposed of prior to the time of administration.

Repeated Violation - 1/6/24

Plan of Correction ***Accept (- 05/20/2024)***

With Respect to the specific deficiency cited:

The violation occurred due to the Med Tech's failure to abide by the policies and procedures taught during their initial medication administration training and the Healthcare Director/Assistant Healthcare Director's failure to conduct a MAR/Medication Cart review.

187d - Follow Prescriber's Orders (continued)

With Respect to Systemic Measures that have been put into place to address the stated concern:
The med tech and nurses were re-trained on regulation 187d on 5/9/24 by the Regional Healthcare Director.

With Respect to How the Plan of Corrective Measures will be Monitored:
The Healthcare Director/Assistant Healthcare Director will oversee the Medication Administration staff to provide support and ongoing compliance and commencing on 5/15/24 via a monthly med cart audit.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Administrator will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented ([redacted] - 09/17/2024)

224a - Preadmission Screen Form

14. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 1's preadmission screening form is not dated, does not indicate whether the resident can safely use and identify poisonous materials, and does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept ([redacted] - 05/20/2024)***

With Respect to the specific deficiency cited:

The home failed to complete a full preadmission screening form for Resident #1. The violation was incurred due to a failure to verify the records were complete.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Resident #1 preadmission screening form cannot be corrected so a new preadmission screening form was completed on 5/2/24.

The Healthcare Director/Assistant Healthcare Director will ensure all resident pre-screening documents are completed within the regulatory parameters utilizing the Resident Record Order checklist form.

To prevent reoccurrence, The Healthcare Director/Assistant Healthcare Director will oversee chart documents are filed timely and in compliance with Legend Resident Record Order.

With Respect to How the Plan of Corrective Measures will be Monitored:

The Healthcare Director/Assistant Healthcare Director will assume compliance monitoring to commence on

224a - Preadmission Screen Form (continued)

5/15/24. The Administrator will review compliance as part of the Quality Assurance meetings. The review will be conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented (- 08/23/2024)

225a - Assessment 15 Days

15. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 9's preadmission screening tool completed on indicates that the resident needs assistance with hygiene, however, the initial assessment, completed , indicates that the resident is independent with hygiene.

Plan of Correction ***Accept (- 05/20/2024)***

With Respect to the specific deficiency cited:

The violation occurred due to the Legend at Silver Creek initial level of care assessment conducted on indicative of the resident care needs to be that of minimal assistance required and the subsequent pre-screen document completion on move in.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Upon physical arrival/move in on 10/31/23 and further understanding of the resident's ability to independently perform hygiene was cascaded to the RASP assessment and incorporated on actual plan of care to meet the true needs of the resident.

With Respect to How the Plan of Corrective Measures will be Monitored:

The Healthcare Director/Assistant Healthcare Director/Designee will complete BHSL forms with full accuracy at time of move in. Beginning 5/15/24, the Administrator will conduct a chart audit on admission for accuracy between the Pre-screen and the RASP.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented (- 08/23/2024)

254a - Records Discharge/Active

16. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 4/30/24, the licensing inspection summary from January 2024 was posted and accessible in the lobby of the home and the privacy coding document identifying several resident's was still attached.

254a - Records Discharge/Active *(continued)*

Plan of Correction ***Accept ([redacted] - 05/20/2024)***

With Respect to the specific deficiency cited:

The former Administrator failed to omit the privacy coding document from the required lobby copy of the LIS.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Corrected at time of inspection. Upon the inspector's arrival and retrieval of the LIS from the lobby [redacted] noted the privacy coding document and [redacted] returned the privacy document to the Administrator for removal from the lobby copy of the home.

With Respect to How the Plan of Corrective Measures will be Monitored:

To prevent this from happening again the Administrator will routinely monitor the public lobby copy of the LIS to ensure the privacy coding is not present and record confidentiality is maintained.

Licensee's Proposed Overall Completion Date: *05/15/2024*

Implemented ([redacted] - 08/23/2024)