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

October 10, 2024

[redacted], OWNER
HERITAGE GROVE AT INDIANA LLC
[redacted]

RE: HERITAGE GROVE AT INDIANA
1703 WARREN ROAD
INDIANA, PA, 15701
LICENSE/COC#: 45516

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/07/2024, 05/08/2024 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: *HERITAGE GROVE AT INDIANA* **License #**: *45516* **License Expiration**: *02/13/2025*

Address: *1703 WARREN ROAD, INDIANA, PA 15701*

County: *INDIANA* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *HERITAGE GROVE AT INDIANA LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/24/1994* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

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

Reason: *Renewal, Interim* **Exit Conference Date**: *05/08/2024*

Inspection Dates and Department Representative

05/07/2024 - On-Site: [redacted]

05/08/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *36*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *2nd floor* **Capacity**: *40* **Residents Served**: *10*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *35*

Diagnosed with Mental Illness: *22* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

05/07/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/09/2024*

07/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/18/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/12/2024*

Inspections / Reviews *(continued)*

07/23/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *09/18/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/16/2024*

10/10/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/18/2024*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

On [redacted], the resident-home contract, dated [redacted], for resident #1, resident-home contract, dated [redacted], for resident #2, were not signed by the resident and did not notate the resident was given opportunity to sign.

On [redacted], there were no contracts completed or any addendum to the current contracts for multiple residents, including for resident #3 and #4, indicating the change of legal entity and any changes to the current contract.

Plan of Correction ***Accept ([redacted] - 07/05/2024)***

Every resident's designated person was mailed an addendum to the contract in March of 2024. This addendum included rate changes, and the new facility name (see attached addendums at end of contracts for residents #3, and 4). Unfortunately, the facility did not receive the signed addendum back from all parties. Resident on #1 and #2's contracts were signed by the resident on [redacted]. Resident #3 signed a new contract on [redacted]. Resident #4's was signed by her designated person after obtaining a statement from a medical professional attesting to the resident's inability to sign any portion of the contract, due to lack of understanding. The facility has developed an addendum to the contract for those future residents who wish to have their designated persons sign their contracts on their behalf (see attached). The signatures from the residents will be collected by the administrator or designee at the same time as contract signing. The only exception being a statement from a medical professional stating the resident lacks the cognitive or physical ability to sign any or all portions of the contract. All contracts indicating that Heritage Grove at Indiana is the new facility name and any changes to the contract will be completed by 6/21/2024. An audit of all contracts to make sure that no signatures were missed will be completed by 6/21/24. The audit and contract signatures will be completed by the administrator or designee.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented ([redacted] - 10/10/2024)

41e - Signed Statement

2. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

On [redacted], resident #4's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept [redacted] - 07/23/2024)***

Resident #4's original contract was signed by the resident's designated person. Resident #4 has been examined by a medical professional and that medical professional has determined that resident #4 lacks the capacity to sign any portion of the contract including a copy of the resident rights (see attached). Moving forward, when it is suspected that a resident lacks the cognitive or physical ability to sign any or all portions of the contract a statement from the

41e - Signed Statement (continued)

medical professional will be obtained. The facility has also created an addendum to the contract that a resident may sign if they wish to have their designated person to sign the contract and all portions of it on their behalf (see attached). This addendum will be signed by residents wishing to do so at the same time of contract signing. This will be the responsibility of the administrator or designee. All residents in the facility will have signatures, or exceptions from medical professionals attesting to their cognitive or physical inability to sign, acknowledging their rights and complaint procedures by 6/21/24. An audit will be conducted by 6/21/24 to make sure no signatures were missed. The audit and signature collection will be done by administrator or designee. The POA documents will be examined upon admission and if the wording in the POA allows for signing of contracts, then a notation will be made that the resident was given the opportunity to sign his or her own contract and elected to have his or her designee or POA sign the document instead. The prior mentioned addendum to the contract has been revised to reflect this notation. Prior signed addendums will have notations added to the record with the permission of both resident (if competent) and POA. These updates will be completed by 7/30/24 MM

Licensee's Proposed Overall Completion Date: *07/30/2024*

Implemented ([redacted] - 10/10/2024)

60a - Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home's staffing schedule indicates the home routinely has 2 staff persons working on the 10:00 pm-6:00 am., shift. In the event of an emergency evacuation, the home's staffing is inadequate to meet the evacuation and supervision needs of the residents. The home serves 34 residents and has identified 18 residents with mobility needs, including 10 residents in the secured dementia care unit (SDCU) on the first floor, 3 needing 2-person physical assistance in transferring for safety, including resident #4, and 3 residents in the personal care area on the second floor, needing 2-person physical assistance in transferring for safety.

Plan of Correction ***Accept ([redacted] - 07/10/2024)***

The facility has adjusted the schedule. Beginning Wednesday 5/29/2024 an additional staff person has been added to the overnight schedule (see attached schedule). The wellness director will continue to assess the residents' needs, monitor the staffing hours, and number of staff in the building at any given time. To prevent this from occurring again, a daily calculation of staffing hours is now discussed in the newly established stand up/morning meetings that started on 5/20/2024. The administrator now tracks daily staffing hours in a spreadsheet as well as the number of immobile residents in the building (see attached spreadsheet). The administrator, the wellness director, and the CEO will continue to collaborate to ensure there is adequate coverage in the building. All staff will be educated on regulation 2600.60.a by 6/21/24. Education will be provided by the administrator or designee. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/07/2024*

Implemented [redacted] - 10/10/2024)

63a - First Aid/CPR Training

4. Requirements

63a - First Aid/CPR Training *(continued)*

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 4/21/24 and 4/27/24, from 10:00 pm.-6:00 am., 34 residents were present in the home. During this time no staff persons were present in the home who was certified in first aid.

On 5/5/24 from 10:00 pm.-6:00 am., 35 residents were present in the home. During this time no staff persons were present in the home who was certified in first aid.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

A new class will be scheduled for those staff members who do not currently have certifications in first aid, AED, and CPR by 6/21/24. Moving forward the schedule will include codes next to staff persons names to indicate who has been trained, to prevent an entire shift from being scheduled without the proper training. The coded schedule will be created beginning 6/9/2024. Newly hired direct care employees will be routinely scheduled for Heartsaver, first aid, AED, and CPR training following 90 days of employment or sooner at the discretion of management. The training will be completed by the administrator who happens to a certified trainer through the American Heart Association. The human resources office will track when the direct care staff members are due for recertification and alert the administrator. New courses will be scheduled prior to the certification's expiration dates. All staff will be educated on regulation 2600.63.a by 6/21/24. Education will be provided by the administrator or designee. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented ([redacted] - 10/10/2024)

89b - Hot Water Temperature

6. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 5/7/24, at 10:35 am., the hot water temperature at the sink in shared bathroom for bedrooms #201 and #202, measured 125.4 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

On 5/7/2024 the maintenance director turned down the temperature on the hot water heater and retested the water temperature later that day. The test later that day was 121 degrees. the maintenance director turned the temperature on the water heater down again to 112 Fahrenheit. The water was tested again on 5/8/2024 and the temperature measured 118 degrees Fahrenheit at that time. The hot water heater will remain set at 112 degrees. Maintenance will measure the water temperatures weekly for one month. If all the temperatures are at or under 120 degrees then the testing will be done monthly. If the water temperature is found to be above 120 degrees the water heater temperature will be adjusted again, and daily temperatures will be taken for a week. If the daily temperatures are 120 degrees and under, then weekly temperatures for a month will resume and move to monthly following acceptable weekly measurements for a month. Documentation will be kept. All staff will be educated on regulation 2600.89.b by 6/21/24. Education will be provided by administrator or designee. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented [redacted] - 10/10/2024)

89b - Hot Water Temperature *(continued)*

91 - Telephone Numbers

7. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 5/7/24, there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in bedroom #141.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

Emergency numbers were reposted again on 5/7/2024, as soon as the inspector made facility staff aware (see attached photo). The numbers were posted by the housekeeping manager. Later that evening, the administrator went into that bedroom and the numbers were removed again, by the resident that resides in that room. The administrator then relocated the emergency numbers onto the wall, instead of the dresser top, and placed it above the phone instead of next to the phone (see attached photo). Housekeeping will be responsible for monitoring placement of emergency telephone numbers. This will be monitored during their normal cleaning of rooms. A checklist will be developed by 6/21/2024. Documentation will be kept. All staff will be educated on regulation 2600.91 by 6.21.24. Education will be given by the administrator or designee. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented [redacted] - 10/10/2024)

101j7 - Lighting/Operable Lamp

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 5/7/24, resident #5, in bedroom #226 and resident #6, in bedroom #132, did not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

The lamp in 132 was immediately fixed by maintenance. A light was provided to resident #5 in bedroom [redacted] on 5/7/2024 by maintenance. Maintenance will conduct monthly rounds and ensure each resident has an operational working lamp or light source within reach at bedside. Documentation will be kept. First set of rounds will be completed by 6/21/24. All staff will be educated on regulation 2600.101.j. Education will be provided by administrator or designee. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented [redacted] - 10/10/2024)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.

103f - Refrigerator/Freezer Temps *(continued)*

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 5/7/24, at 1:28 pm., the temperature in the side-by-side freezer was 28 degrees Fahrenheit.

On 5/7/24, at 1:34 pm., the temperature in the side-by-side refrigerator was 33 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

CEO was contacted by maintenance director about the malfunctioning freezer on 5/7/2024. A vendor was contacted by maintenance director on 5/7/2024. A vendor repaired the freezer on the morning of 5/8/2024 and new temperatures were taken on 5/8/2024 that measured 0 degrees. The freezer temperature log will continue to be maintained by dietary staff and checked each day by the kitchen manager. If at any time the temperature measures higher than 0 degrees Fahrenheit, the maintenance director will be notified immediately to investigate. All dietary staff and maintenance staff will be educated on this by 6/21/2024. All staff will be made aware of regulation 2600.103.f by 6/21/24. Education will be done by administrator or designee. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented ([redacted] - 10/10/2024)

103g - Storing Food

10. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 5/7/24, there was an opened and unsealed bag of precooked bacon in the kitchen's walk-in refrigerator.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

The opened bag of bacon was immediately placed into a sealed container on 5/7/2024 by the kitchen manager. The kitchen manager will reeducate the dietary staff on the regulations of food storage by 6/21/2024. All staff will be educated on the regulations of food storage by 6/21/2024. The kitchen manager will conduct weekly audits to ensure there are not any unsealed items being stored in the walk-in refrigerator or elsewhere in the kitchen. The checklist will be developed by 6/21/2024. The first audit will be conducted by 6/24/2024. Documentation will be kept. Weekly audits will continue for a period of three months. Then monthly audits will occur, unless during the weekly audits unsealed opened items are found. Weekly audits will continue until a period of time when three months have passed without opened unsealed items being found. Monthly audits will remain as a safety check. All staff will be made aware of regulation 2600.103.g by 6/21/24. Education will be given by administrator or designee. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/24/2024*

Implemented [redacted] - 10/10/2024)

103i - Outdated Food

11. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food *(continued)*

Description of Violation

On 5/7/24, there was an unlabeled, undated opened bag of omelets, sausage patties, and ball of dough in kitchen side-by-side freezer.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

All items were immediately placed into proper storage containers and open dates clearly marked by the kitchen manager on 5/7/24. The kitchen manager will reeducate the dietary staff on the regulations of food storage by 6/21/2024. All staff will be educated on the regulations of food storage by 6/21/2024. The kitchen manager will conduct weekly audits to ensure there are not any unsealed or outdated items being stored in the freezer or elsewhere in the kitchen. The checklist will be developed by 6/21/2024. The first audit will be conducted by 6/24/2024. Documentation will be kept. Weekly audits will continue for a period of three months. Then monthly audits will occur, unless during the weekly audits unsealed opened items are found. Weekly audits will continue until a period of time when three months have passed without errors being found. Monthly audits will remain as a safety check. All staff will be educated on regulation 2600.103.i by 6/21/24. Education will be by administrator or designee. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/24/2024*

Implemented ([redacted] - 10/10/2024)

132f - Alternate Exit Routes

12. Requirements

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

Description of Violation

The home has only used the ground level exit route for the first floor SDCU and second floor personal care during the fire drills held from 11/27/23 to 4/30/24.

Plan of Correction ***Accept ([redacted] - 07/23/2024)***

The facility will begin to alternate fire exit doors or evacuate residents to fire safe areas beginning with the fire drill in June of 2024. The exit doors that are used for each fire drill will be documented on the fire drill log. Maintenance will continue to conduct the fire drills. All staff will be educated on 2600.132.f by 6/24/24. Education will be done by administrator or designee. Documentation will be kept.
Staff was informed of the regulation 2600.132.f on 6/21/24. Staff members were informed of the intention to move residents to alternate exit routes or fire safe areas. The June fire dire had residents evacuated to the stairwell instead of an outside area. This was the alternate area that the facility used for the month of June.

Licensee's Proposed Overall Completion Date: *07/15/2024*

Implemented ([redacted] - 10/10/2024)

141b1 - Annual Medical Evaluation

13. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

On 5/7/24, resident #3's medical evaluation, dated [redacted], indicated "see attachment" for medication information.

141b1 Annual Medical Evaluation (continued)

However, there was no medication attachment provided.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

A current list of medications was obtained for resident #3 and signed by the physician on [redacted]. The list of medications was attached to the DME. An audit will be conducted on all resident's charts to ensure DMEs are complete. Audit will be conducted by wellness director or designee. Audit will be completed by 7/9/2024. Moving forward newly acquired and renewed DMEs will be reviewed by wellness director and the administrator. Once the DME is reviewed and error free, one copy will be stored in the resident's hard copy chart in the medication room. A second copy will be stored in the administrative file in the administrator's office. This will prevent the facility from misplacing the "attachment," in the future. All staff will be educated on regulation 2600.141.b.1 by 6/21/24. Education will be given by administrator or designee. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/09/2024*

Implemented ([redacted] - 10/10/2024)

161d - Dietary Needs

14. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On [redacted], resident #3 was prescribed a mechanical soft diet. However, on [redacted], at approximately [redacted], the resident was served approximately 2" cut up pieces of baked potatoes.

Plan of Correction ***Directed ([redacted] - 07/23/2024)***

Administration has re educated the dietary staff on the importance of cutting mechanical soft foods into bite sized pieces per American Dietetic Guidelines. Administration has reached out to third party hospice vendors to schedule a formal training with a registered dietician to train all dietary staff and direct care staff on the different types of diets and the importance of following them. Estimated time frame for completion of training 8.15.24 MM Documentation will be kept.

Proposed Overall Completion Date: 08/15/2024

DIRECTED PLAN:
By 8/15/24 and at least weekly thereafter for two months: the Administrator or designee shall observe a meal to ensure residents' special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian are met.

Directed Completion Date: *08/15/2024*

Implemented ([redacted] - 10/10/2024)

183d - Prescription Current

15. Requirements

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

183d - Prescription Current *(continued)*

Description of Violation

On [redacted] the following discontinued medications, for resident #2 were in medication cart. These medications were discontinued on [redacted]:
*[redacted]
*[redacted]
On 5/8/24, the discontinued medication, [redacted], for resident #4 was in medication cart.

Plan of Correction ***Accept ([redacted] - 07/10/2024)***

The discontinued medications were removed from the cart and destroyed per facility policy 5/8/24 by the wellness director and lead medication aide. Weekly medication cart audits will be done by the wellness director or designee. Weekly medication cart audits will continue until a time period has passed that three months have elapsed that no discontinued medications were found to have been lingering in the medication carts. The audits should be error free. All medication aides will be educated on regulation 2600.183.d by 6/21/24. Documentation of education and audits will be kept.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented ([redacted] - 10/10/2024)

183e - Storing Medications

16. 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

Resident #1 is prescribed, [redacted] at bedtime. On [redacted], resident #1's [redacted] was open and not dated with the open date. According to the manufacturer's instructions the medication expires 28 days after opening.

Plan of Correction ***Accept ([redacted] - 07/10/2024)***

The wellness director was unable to calculate the exact open date of the [redacted] pen. However, to determine if the pen was still within the 28 days, the wellness director calculated the sum of 28 units per day x 28 days=784. 784 divided by 300(total units in a pen)=2.6. Determining that it takes 2.6 Basglar pens @28 units per day, to last through that 28 days. This satisfied that the pen in question with no open date would have to have been within the 28 days, and therefore not expired. Weekly medication cart audits will be done by the wellness director or designee. Weekly medication cart audits will continue until a time period has passed that three months have elapsed that no medications were found without an open date. The audits should be error free. All medication aides will be educated on regulation 2600.183.e by 6/21/24. Documentation of education and audits will be kept.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented ([redacted] - 10/10/2024)

184a - Resident's Meds Labeled

17. Requirements

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

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

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 #1's [redacted], was smeared and unable to clearly read.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

The wellness director contacted the pharmacy on 5/8/2024 and a new label was printed. The new label was affixed to the package by the wellness director. Weekly medication cart audits will be done by the wellness director or designee. Weekly medication cart audits will continue until a time period has passed that three months have elapsed that all medications in the cart have a clear easy to read label affixed. The audits should be error free. All medication aides will be educated on regulation 2600.184.a by 6/21/24. Documentation of education and audits will be kept.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented ([redacted] - 10/10/2024)

185a - Implement Storage Procedures

18. 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 #3 is prescribed [redacted] four times per day, before each meal and at bedtime. On [redacted], at [redacted] resident #3's glucometer indicated a reading of [redacted]; however, it is not included on resident #3's [redacted] medication administration record (MAR).

Resident #3's glucometer is missing readings for the period of [redacted]. The home indicated a spare glucometer for resident #3 was used. However, the spare glucometer could not be found. The home did have multiple unlabeled glucometers, some that did not work and one that had reading dated for 2022.

Plan of Correction ***Accept [redacted] - 07/10/2024)***

All unlabeled glucometers and unlabeled supplies were disposed of by the wellness director on 5/8/2024. Clearly marked places inside the cabinet were marked with resident names by the wellness director on 5/8/2024. Glucometers inside the medication carts were clearly labeled again by the wellness director on 5/8/2024. All staff will be educated on regulation 2600.185.a. by 6/21/24. Education will be done by administrator or designee. Weekly audits of glucometers will be started the week of 6/24/24. A new log sheet to check the inventory of supplies of diabetic supplies for residents has been implemented (see attached). This is to prevent the need to use back up glucometers. Wellness director will monitor this new system for accuracy, by looking at the log sheets five days a week.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented ([redacted] - 10/10/2024)

227d - Support Plan Medical/Dental

19. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

On [redacted] resident #2's support plan, dated [redacted], does not document home health contact information.

On [redacted], resident #3's support plan, dated [redacted], does not indicate a mechanical soft diet and how this need will be met. Resident's #3's support plan indicates "regular diet".

On [redacted], resident #5's support plan, dated [redacted], does not indicate the resident's use of a [redacted] device and the specific need for the enabler device and the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, ad identification of the specific device to be used and whether a cover is required to meet FDA guidelines

Repeat violation: 11/30/23

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The missing phone number for home health services was added to the RASP on [redacted] by the wellness director for resident #2. The wellness director corrected the diet on the RASP for resident #3 on [redacted]. Since that date resident #3's diet has changed again, and the wellness director updated the RASP of resident #3 to reflect that change. Resident#5's enabler was on the RASP. This exact wording was already approved by the department previously in the plan of correct and scanned items returned in February of 2024. An order was obtained for resident #5 to use the [redacted] device on [redacted]. The [redacted] and its associated risks will be added to the RASP for resident #5. Resident number #5 will have an entirely new RASP completed by [redacted] The wellness director will complete the new RASP. The wellness director will give a copy of the completed rasp to the administrator for review by 6/14/21. House wide audit of all RASPs will be completed by [redacted]. The wellness director or designee will complete audits. Documentation will be kept. All direct care staff be educated on regulation 2600.227.d by 6/21/24. Education will be provided by administrator. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/09/2024*

Implemented [redacted] - 10/10/2024)