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

December 4, 2024

, MANAGING DIRECTOR
HIDDEN MEADOWS OPCO LLC

RE: HIDDEN MEADOWS ON THE RIDGE
340 FARMERS LANE
SELLERSVILLE, PA, 18960
LICENSE/COC#: 14523

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/21/2024, 05/22/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HIDDEN MEADOWS ON THE RIDGE* **License #**: *14523* **License Expiration**: *07/20/2024*

Address: *340 FARMERS LANE, SELLERSVILLE, PA 18960*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *HIDDEN MEADOWS OPCO LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/02/2010* **Issued By**: *West Rockhill Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *60* **Waking Staff**: *45*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *05/22/2024*

Inspection Dates and Department Representative

05/21/2024 - On-Site:

05/22/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *51*

Secured Dementia 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**: *51*

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

Have Mobility Need: *9* **Have Physical Disability**: *2*

Inspections / Reviews

05/21/2024 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/21/2024*

06/28/2024 - POC Submission

Submitted By: **Date Submitted**: *07/29/2024*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/03/2024*

Inspections / Reviews *(continued)*

07/19/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *07/29/2024*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date:** *07/29/2024*

12/04/2024 Document Submission

Submitted By: [redacted]
Date Submitted: *07/29/2024*
Reviewer: [redacted]
Follow Up Type: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 05/22/2024 around 11:00 AM, the 2nd floor narcotic book was placed on the 2nd floor medication cart, unlocked, unattended, and accessible to anybody.

Plan of Correction ***Accept (- 07/19/2024)***

This violation was reviewed by this administrator with direct care staff at a team meeting on 5/29/24 see attached sign in and agenda

A Med tech/nursing meeting is scheduled on 7/3/24 to review more in depth HIPAA and proper storage of residents confidential information by this Administrator and Director of Health and Wellness.

Safety checks will be conducted monthly and indefinitely by this Administrator beginning 6/19/24, see attached Checks will be reviewed with leadership by this administrator/executive director at annual Quality Management Meeting. An additional QMP to review checks and POC with the leadership team is scheduled for 7/2/24, see attached agenda and minutes

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 12/04/2024)

28e - Death of a Resident

2. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101— 10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #1 passed away on The resident's personal belongings were removed on ; however, the resident's refund check was not issued until .

Plan of Correction ***Accept (- 07/19/2024)***

A new policy and procedure was developed by this Administrator/Executive Director and is effective 6/21/24 to help ensure timely completion of refunds after a resident passes away.

Resident file checklist has been updated by this administrator on 6/21/24(in conjunction with the new policy), the purpose of the resident file checklist is to ensure that all tasks related to administration of the file, are completed in a timely manner and staff are kept accountable for completion of each item. The addition to the checklist is to notate if a refund is due, and when refund was made in order to better track the status and documentation of the refund.

To ensure compliance, training for the business office and other managers on the new procedure will be provided at the quality management meeting by this administrator on 7/2/24, see attached record of training.

Move outs who are owed refunds will be reviewed by the business office manager at quality management meeting also on 7/2/24, see attached agenda and minutes

28e - Death of a Resident *(continued)*

Licensee's Proposed Overall Completion Date: *07/02/2024*

Implemented (- 12/04/2024)

28f - Resident's Funds and 30-day Refund

3. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #2 moved out ; however, the home did not issue the refund check until

Plan of Correction ***Accept (- 07/19/2024)***

A new policy and procedure was developed by this Administrator/Executive Director and is effective June 21, 2024 to help ensure timely completion of refunds after a resident moves out.
Resident file checklist has been updated by this administrator on 6/21/24(in conjunction with the new policy), the purpose of the resident file checklist is to ensure that all tasks related to administration of the file, are completed in a timely manner and staff are kept accountable for completion of each item. The addition to the checklist is to notate if a refund is due, and when refund was made in order to better track the status and documentation of the refund.
To ensure compliance, training for the business office and other managers on the new procedure will be provided at the quality management meeting by this administrator on 7/2/24, see attached record of training.
Move outs who are owed refunds will be reviewed by the business office manager at quality management meeting also on 7/2/24, see attached agenda and minutes

Licensee's Proposed Overall Completion Date: *07/02/2024*

Implemented (- 12/04/2024)

42c - Treatment of Residents

4. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On early in the morning around , staff A said to resident #3 who was trying to do some stretching before going back to bed, "Listen, I don't have all day." Then, staff A lifted the resident's legs roughly on the bed, threw a pillow at the resident and left the resident's room without tucking him/her in bed.

Plan of Correction ***Accept - 07/19/2024)***

Staff person A was terminated upon completion of this investigation.
HMOR care staff were trained by this administrator/executive director on 5/29/24 regarding resident rights and de-escalation, see attached meeting agenda and sign in.
To prevent re-occurrence, monthly nursing meetings will be held with the Director of Health and Wellness and/or this administrator, starting 7/3/24 to review resident concerns with staff.
To monitor compliance meeting minutes will be reviewed by the director of health and wellness at quality management meetings, next meeting is 7/2/24

42c - Treatment of Residents *(continued)*

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 12/04/2024)

54a - Direct Care Staff

5. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept - 07/19/2024)***

Direct care staff person A has a Bachelors Degree from home country, which is above a high school diploma.
This staff person has been terminated, so no further action is needed regarding a waiver for education.
The age and education requirement policy has been updated on June 19, 2024 by this administrator.
The business office manager and assistant business office manager, who are tasked with onboarding new employees, have been educated by this administrator on 6/20/24 of this requirement and new policy. See attached policy and sign off sheet.
To monitor compliance, this administrator will conduct monthly employee file audits beginning 6/24/24, and will be done indefinitely.
Audits will be reviewed at annual Quality Management Meetings by this administrator, next meeting will be held on 7/2/24, see attached agenda

Licensee's Proposed Overall Completion Date: *07/02/2024*

Implemented (- 12/04/2024)

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A received only 4.5 hours of annual training in training year 2023.
Direct care staff person C received only 10.25 hours of annual training in training year 2023.

Plan of Correction ***Accept - 07/19/2024)***

Unfortunately, HMOR transferred employee training records to another software platform and some trainings were lost in the transfer.
Staff person A has been terminated, however staff Person C has received an additional 7 hours supplemental training, see attached training acknowledgement
To monitor compliance and prevent reoccurrence, this administrator will conduct monthly employee file audits and Relias audit beginning 6/24/24, see attached audit form. Audits will be completed indefinitely and maintained in the administrators office.
Audits will be reviewed by this administrator at annual Quality Management Meetings, next meeting will be held

65e - 12 Hours Annual Training (continued)

on 7/2/24, see attached agenda

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (█ - 12/04/2024)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
3. Care for residents with dementia and cognitive impairments.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff A did not receive training in the topics of medication self-administration, care for residents with dementia or cognitive impairment, safe management techniques, and care for residents with mental illness or an intellectual disability during training year 2023.
Direct care staff person C did not receive training in the topics of medication self-administration, safe management techniques, and care for residents with mental illness or an intellectual disability during training year 2023.

Plan of Correction ***Accept (█ - 07/19/2024)***

Staff person A was terminated, however staff person C completed supplemental training on 6/1, 6/3, 6/11, and 6/20/24 to cover these topics that were missed last year, see attached training transcript and supplemental training acknowledgement.
To monitor compliance, this administrator will conduct monthly employee file audits beginning 6/24/24, see attached audit form. Audits will be conducted monthly, indefinitely
Audits will be reviewed by this administrator at annual Quality Management Meetings, next meeting will be held on 7/2/24, see attached agenda

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (█ - 12/04/2024)

65g - Annual Training Content

9. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
5. Falls and accident prevention.

Description of Violation

Staff person A and C did not receive training in the topics listed above during training year 2023.

Plan of Correction ***Accept (█ - 07/19/2024)***

Staff person A was terminated, however staff person C completed supplemental training on 4/17, 6/6, 6/20/24 that

65g - Annual Training Content (continued)

covers these topics that were missed last year, see attached training transcript and supplemental training acknowledgment.
To monitor compliance, this administrator will conduct employee file audits beginning 6/24/24, see attached audit form. File audits will be conducted monthly, indefinitely
Audits will be reviewed by this administrator at annual Quality Management Meetings, next meeting will be held on 7/2/24, see attached agenda

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 12/04/2024)

81b - Resident Personal Equipment

10. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #3's bed is equipped with a bedside mobility device, which was not securely attached to the bed frame. This device was attached to a wooden board that was slid under the mattress and could be pulled out easily. Bedside mobility devices that slide under the mattress and are not securely attached to the structure of the bed can move and create entrapment zones not always present upon inspection. These types of devices are not permitted under any circumstances.

Plan of Correction ***Accept (- 07/19/2024)***

At time of inspection, this residents mobility device was secured properly to the bed.
To monitor compliance, monthly safety checks will be completed by this administrator indefinitely and maintained in the administrators office.
First safety check was conducted 6/19/24 and all mobility devices were checked for proper installation, see attached completed safety check form.
Checks will be reviewed by this administrator at annual Quality Management Meeting scheduled 7/2/24. See attached minutes

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 08/26/2024)

85a - Sanitary Conditions

11. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 05/22/2024 at 10:38 AM, a yellow crusted stain about 2 inches in diameter was observed inside the medication refrigerator located in the 3rd floor wellness office. In the refrigerator was a plastic container with left-over food and a can of beer along with some residents' insulin pens and eye drops.

Plan of Correction ***Accept (- 07/19/2024)***

Old medication refrigerator was removed and a new, smaller medication refrigerator was purchased. See attached picture.

85a - Sanitary Conditions (continued)

Compliance will be monitored through Medication Room and Cart/MAR audits. See attached audit form. Audits will be conducted by Pharmacy quarterly and indefinitely starting 6/25/24 and Director of health and Wellness on a Monthly Basis and indefinitely on 7/1/24.
Cart/Med Room Audits will be reviewed by the Director of Health and Wellness at annual Quality Management Meeting. Next meeting is scheduled for 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 08/26/2024)

85e - Trash Outside Home

12. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 05/22/2024, the home's dumpster was missing a top covering. There was also a broken beige recliner thrown on the side of the dumpster.

Plan of Correction ***Accept - 07/19/2024)***

After inspection, the trash company was contacted to repair broken lid on the dumpster. Please picture of repaired dumpster lid and cleared area around bin.
To monitor compliance, safety checks will be conducted monthly by this Administrator beginning 6/19/24, checks will be completed indefinitely and documentation will be maintained in administrators office.
Checks will be reviewed by this administrator at the annual quality management meeting on 7/2/24, see attached meeting minutes

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 08/26/2024)

96a - First Aid Kit

13. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the home's bus does not include eye coverings and breathing shield.

Plan of Correction ***Accept (- 07/19/2024)***

After inspection, the first aid kit in the bus was restocked with all new required items including CPR mask and eye coverings and list of required items attached to kit box.
To monitor compliance, safety checks will be conducted monthly by this Administrator beginning 6/19/24, checks will be completed indefinitely and documentation will be maintained in administrators office.
Checks will be reviewed by this administrator at the annual quality management meeting on 7/2/24, see attached meeting minutes

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 08/26/2024)

96a - First Aid Kit *(continued)*

103i - Outdated Food

14. Requirements

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

Description of Violation

Three 50 oz cans of cream of chicken soup which expired 10/19/23 and three 50 oz cans of tomato soup which expired 4/25/24 were found in the home's emergency food storage.

Repeat Violation; 01/04/2023

Plan of Correction ***Accept (- 07/19/2024)***

At time of inspection, those items were removed.
To monitor compliance, safety checks will be conducted monthly by this Administrator beginning 6/19/24, checks will be completed indefinitely and documentation will be maintained in administrators office.
Checks will be reviewed by this administrator at the annual quality management meeting on 7/2/24, see attached meeting minutes

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 08/27/2024)

121a - Unobstructed Egress

15. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 05/21/2024 around 09:45 AM, a red stop sign with "emergency exit only!" printed on a white paper was posted on the exit door of the third floor near resident room #311.

Plan of Correction ***Accept (- 07/19/2024)***

At time of inspection, the signage was removed.
This violation was reviewed with care staff on 5.29.24 by this administrator.
Additional training for maintenance staff and this administrator with a fire safety expert is scheduled on 6/24/24 to review this regulation and compliance of.
To monitor compliance, safety checks will be conducted monthly by this Administrator beginning 6/19/24, checks will be completed indefinitely and documentation will be maintained in administrators office.
Checks will be reviewed by this administrator at the annual quality management meeting on 7/2/24, see attached meeting minutes

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 12/04/2024)

131a - Fire Extinguisher

16. Requirements

131a Fire Extinguisher *(continued)*

2600.
131.a. There shall be at least one operable fire extinguisher with a minimum 2 A rating for each floor, including the basement and attic.

Description of Violation

On 05/21/2023 around 09:40 AM, the fire extinguisher located right inside the home's front entrance was undercharged.

Plan of Correction ***Accept ██ - 07/19/2024)***

HMOR utilizes an outside provider to inspect all of our sprinklers and fire extinguishers. this company was notified of the undercharged fire extinguisher at the time of inspection and replaced the extinguisher, see attached picture.
On top of the 3rd party inspections, to monitor compliance of this regulation, a safety check was conducted on 6/19/24 by this administrator to include checking all fire extinguishers in the building, see attached check sheet.
Safety checks will be conducted monthly by this administrator and indefinitely and documentation will be maintained in administrators office.
Checks will be reviewed by this administrator at the annual quality management meeting on 7/2/24, see attached meeting minutes

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ██ - 08/27/2024)

132c Fire Drill Records

17. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 01/15/2024 does not include the exact location of the fire and exit routes used by the resident
The fire drill record for the drill conducted on 02/28/2024 does not include the exact amount of time for evacuation and exact exit routes used by the resident.

Plan of Correction ***Accept (██ - 07/19/2024)***

To prevent reoccurrence, additional training for the maintenance team and this administrator who are in charge of conducting drills is scheduled 6/24/24 with a fire safety expert to cover this topic, see attached sign in.
New fire drill policy and procedure was developed effective 7/1/24 by this administrator with the consultation of a fire safety expert, see attached.
Training on this policy was conducted 7/1/24 by this administrator with maintenance staff who conduct and document drills.
To monitor compliance fire drill reports will be reviewed by the director of facility operations at quality management meetings, next meeting is scheduled 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (██ - 08/27/2024)

132h - Designated Meeting Place

18. Requirements

2600.
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 the fire drill on 02/28/2024 at 03:20 PM, only 29 residents out of 50 residents onsite evacuated to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept (- 07/19/2024)***

To prevent reoccurrence, additional training for the maintenance team and this administrator who are in charge of conducting drills is scheduled 6/24/24 with a fire safety expert to cover this topic, see attached sign in.
New fire drill policy and procedure was developed effective 7/1/24 by this administrator with the consultation of a fire safety expert, see attached.
Training on this policy was conducted 7/1/24 by this administrator with maintenance staff who conduct and document drills.
To monitor compliance fire drill reports will be reviewed by the director of facility operations at quality management meetings, next meeting is scheduled 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 08/27/2024)

141a - Medical Evaluation

19. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #4 was admitted to the home on . However, the resident's medical evaluation was complete on .

Plan of Correction ***Accept (- 07/19/2024)***

To prevent re-occurrence, Nursing/med tech meeting is scheduled 7/3/24 to provide additional training on DME and other DHS required forms.
To monitor compliance, this administrator will conduct monthly resident file audits starting 6/19/24, see attached.
Audits will be completed indefinitely and documentation will be maintained in the administrators office.
Audits will be reviewed at the annual quality management meeting, next meeting is scheduled 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 12/04/2024)

141a 1-10 Medical Evaluation Information

20. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #5's medical evaluation dated [redacted] is checked on n/a on (8) Body positioning and movement stimulation when the resident uses a bedside mobility device for transfer.

Plan of Correction ***Accept [redacted] - 07/19/2024)***

DME has been updated by this administrator and sent to the Physician to acknowledge. See attached email communication to physicians office.
To prevent re-occurrence, Nursing/med tech meeting is scheduled 7/3/24 to provide additional training by this administrator on DME and other DHS required forms.
To monitor compliance, this administrator will conduct monthly resident file audits starting 6/19/24, see attached.
Audits will be done indefinitely and documentation will be maintained in the administrators office.
Audits will be reviewed at the annual quality management meeting, next meeting is scheduled 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented [redacted] - 12/04/2024)

141b1 - Annual Medical Evaluation

21. Requirements

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

Description of Violation

Resident #4's most recent medical evaluation was completed on [redacted] The resident's previous medical evaluation was completed on [redacted].

Plan of Correction ***Accept [redacted] - 07/19/2024)***

A full one time audit of all residents medical evaluations was completed on 7/2 by the director of health and wellness and this administrator to check for compliance. See attached check sheet
To prevent re-occurrence, Nursing/med tech meeting is scheduled 7/3/24 to provide additional training by this administrator on DME and other DHS required forms. See minutes and agenda
To monitor compliance, this administrator will conduct monthly resident file audits starting 6/19/24, see attached.
Audits will be done indefinitely and documentation will be maintained in the administrators office.

141b1 - Annual Medical Evaluation (continued)

Audits will be reviewed by this administrator at the annual quality management meeting, next meeting is scheduled 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 12/04/2024)

183d - Prescription Current

22. Requirements

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

Description of Violation

On , a prescribed for resident #6 was in the home's 1st floor medication cart; however, the medication was not listed on the resident's current order.

Repeat Violation: 01/04/2023

Plan of Correction ***Accept - 07/19/2024)***

Residents kit was disposed of as he does not have a current order for it. Pharmacy was contacted to conduct a full audit of all med carts to ensure no additional violations were present. See attached audit from 6/28/24
To prevent re-occurrence, Med Tech/Nursing team meeting is scheduled 7/3/24 to educate staff of this regulation by this administrator.
Compliance will be monitored through Medication Room and Cart/MAR audits. See attached audit form. Audits will be conducted by Pharmacy quarterly, starting 6/28/24 and by Director of health and Wellness on a Monthly Basis 7/1/24. These audits will be conducted indefinitely and documentation will be maintained in the Administrators office
Audits will be reviewed by the director of health and wellness at annual Quality Management Meeting. Next meeting is scheduled for 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented (- 12/04/2024)

183e - Storing Medications

23. 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 05/22/2024 around 10:40 AM, the thermometer in the medication refrigerator kept in the 3rd floor wellness office displayed 50°F. Inside the refrigerator were found unopened insulin pens and eye drops. According to the manufacturer’s instructions, both the unopened insulin pens and eye drops are recommended to be stored in a refrigerator at approximately 36°F to 46°F.

183e - Storing Medications (continued)

A blister pack of [redacted] prescribed for resident #7 with an expiration date of [redacted] was still in the 3rd floor medication cart.

Plan of Correction ***Accept [redacted] - 07/19/2024)***

Old refrigerator was removed and replaced on June 13th (see attached picture of delivery confirmation) with a new medication refrigerator that has as external temperature display, see picture.
Expired [redacted] was disposed of by nursing staff on 5/22/24 according to facility narcotic disposal policy see attached narc sheet with documentation of disposal
Compliance of the medication refrigerator will be monitored through monthly safety checks, completed by this Administrator beginning on 6/19/24.
Compliance with medication storage will be monitored through Medication Room and Cart/MAR audits. See attached audit form. Audits will be conducted by Pharmacy quarterly, starting 6/28/24 and Director of health and Wellness on a Monthly Basis 7/1/24. These audits will be conducted indefinitely and documentation will be maintained in the administrators office
Med Tech/Nursing team meeting is scheduled 7/3/24 to review this regulation by this Administrator and Director of Health and Wellness.
Audits will be reviewed by the director of health and wellness at annual Quality Management Meeting. Next meeting is scheduled for 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented [redacted] - 12/04/2024)

184a - Resident's Meds Labeled

24. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #6 is prescribed [redacted] and [redacted] as needed. The pharmacy label for this medication read 1 vial every 6 hours as needed, requiring a direction change sticker.

Plan of Correction ***Accept [redacted] - 07/19/2024)***

Change sticker was applied at time of inspection. On 5/29/24 a care staff meeting was held and this violation was reviewed with staff by this administrator, see attached minutes and sign in sheet.
An additional nursing/med tech meeting will be held by this administrator and will provide additional training on this regulation on 7/3/24
To monitor compliance, Med/Cart Audits will be conducted
Audits will be conducted by Pharmacy quarterly, starting 6/28/24 and Director of health and Wellness on a Monthly Basis 7/1/24. Audits will be done indefinitely and documentation will be maintained in the administrators office
Audits will be reviewed by the director of health and wellness at annual Quality Management Meeting. Next meeting is scheduled for 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented [redacted] - 12/04/2024)

185a Implement Storage Procedures

25. 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] every 4 hours as needed. On [redacted], this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 07/19/2024)***

To prevent re-occurrence, Staff will be trained by this administrator on this subject at a med tech/nursing meeting on 7/3/24
To monitor compliance, Med/Cart Audits will be conducted by Pharmacy quarterly, starting 6/28/24 and Director of health and Wellness on a Monthly Basis 7/1/24. Audits will be done indefinitely and documentation will be maintained in the administrators office
Audits will be reviewed by the director of health and wellness at annual Quality Management Meeting. Next meeting is scheduled for 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 12/04/2024)

187b Date/Time of Medication Admin.

26. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #6 is prescribed [redacted] twice a day as needed. The resident's May medication administration record (MAR) does not include the initials of staff person D who administered it on [redacted].

Plan of Correction ***Accept ([redacted] - 07/19/2024)***

On 5/29/24 this violation was addressed at a care staff team meeting by this administrator, see attached meeting minutes and sign in
To prevent re-occurrence, Staff will be trained by this administrator on this subject at a med tech/nursing meeting on 7/3/24
To monitor compliance, Med/Cart Audits will be conducted by Pharmacy quarterly, starting 6/28/24 and Director of health and Wellness on a Monthly Basis 7/1/24. Audits will be done indefinitely and documentation will be maintained in the administrators office
Audits will be reviewed by the director of health and wellness at annual Quality Management Meeting. Next meeting is scheduled for 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 12/04/2024)

224a Preadmission Screen Form

27. Requirements

2600.

224a Preadmission Screen Form *(continued)*

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 #8's preadmission screening form, dated [redacted], 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] - 07/19/2024)***

Pre admission screen has been updated, see attached
A full audit has been completed on 7/2/24 of all residents Pre Admission screens by the director of health and wellness and this administrator to ensure determination section has been completed, see attached
To prevent re occurrence, Nursing/med tech meeting is scheduled 7/3/24 to provide additional training on DME and other DHS required forms by this administrator.
To monitor compliance, this administrator will conduct monthly resident file audits starting 6/19/24, see attached.
Audits will be done indefinitely and documentation will be maintained in the administrators office
Audits will be reviewed by this administrator at the annual quality management meeting, next meeting is scheduled 7/2/24 see attached minutes

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented ([redacted] - 12/04/2024)

227d - Support Plan Medical/Dental

28. 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

Resident #5 uses a bedside mobility device to assist with transfer. However, the resident's assessment and support plan (RASP) dated 05/10/2024 does not address this use.

Repeat Violation: 01/04/2023

Plan of Correction ***Accept [redacted] - 07/19/2024)***

RASP was updated after the inspection on [redacted] by this administrator, see attached
A full audit of all rasps has been completed on [redacted] by the director of health and wellness to ensure that all residents with bedside mobility devices has been properly documented in the RASP. See attached
To prevent re occurrence, Nursing/med tech meeting is scheduled [redacted] to provide additional training on DME and other DHS required forms by this administrator/executive director.
To monitor compliance, this administrator will conduct monthly resident file audits starting [redacted], see attached
Audits will be reviewed by this administrator at the annual quality management meeting, next meeting is scheduled 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented [redacted] - 12/04/2024)

227g -Support Plan Signatures

29. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #5's RASP dated [redacted] was not signed by the assessor and was signed but not dated by the resident.

Plan of Correction ***Accept ([redacted] - 07/19/2024)***

RASP had been completed, reviewed and signed by resident on [redacted], however, the assessor had failed to sign also. [redacted] signed the RASP after the inspection on [redacted].
A full audit of all residents RASPs has been completed by the director of health and wellness and this administrator to ensure they all have been properly signed by all parties involved, see check sheet
To prevent re-occurrence, Nursing/med tech meeting is scheduled 7/3/24 to provide additional training on DME and other DHS required forms by this administrator see minutes and sign in
To monitor compliance, this administrator will conduct monthly resident file audits starting 6/19/24, see attached.
Audits will be completed indefinitely and documentation will be maintained in the administrators office.
Audits will be reviewed by this administrator at the annual quality management meeting, next meeting is scheduled 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented [redacted] - 12/04/2024)

252 - Record Content

30. Requirements

2600.
252. Content of Resident Records - Each resident’s record must include the following information:
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.

Description of Violation

Resident #5's record does not include the preadmission screening form.

Plan of Correction ***Accept [redacted] - 07/19/2024)***

To prevent re-occurrence, Nursing/med tech meeting is scheduled [redacted] to provide additional training by this administrator on DME and other DHS required forms.
To monitor compliance, this administrator will conduct monthly resident file audits starting 6/19/24 and will be done indefinitely, see attached
Audits will be reviewed by this administrator at the annual quality management meeting, next meeting is scheduled 7/2/24

Licensee's Proposed Overall Completion Date: *07/03/2024*

Implemented [redacted] - 12/04/2024)