Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

September 24, 2024

[REDACTED], OWNER
APRONTREE PERSONAL CARE LLC
18015 PATH VALLEY ROAD
SPRING RUN, PA, 17262

RE: APRONTREE PERSONAL CARE
18015 PATH VALLEY ROAD
SPRING RUN, PA, 17262
LICENSE/COC#: 33449

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *APRONTREE PERSONAL CARE* **License #**: *33449* **License Expiration**: *11/08/2024*

Address: *18015 PATH VALLEY ROAD, SPRING RUN, PA 17262*

County: *FRANKLIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *APRONTREE PERSONAL CARE LLC*

Address: *18015 PATH VALLEY ROAD, SPRING RUN, PA, 17262*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *Other* **Date**: *08/21/1985* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *19* **Waking Staff**: *14*

Inspection Information

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

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

Inspection Dates and Department Representative

05/22/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *21* **Residents Served**: *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *11* **Are 60 Years of Age or Older**: *18*

Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

05/22/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/16/2024*

06/21/2024 - POC Submission

Submitted By: **Date Submitted**: *07/19/2024*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/28/2024*

Inspections / Reviews *(continued)*

07/01/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/19/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date**: *07/19/2024*

09/24/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *07/19/2024*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home's furnace burns oil to heat part of the home. The basement, where the furnace is located, it not equipped with a carbon monoxide detector.

Plan of Correction ***Accept (- 07/01/2024)***

-A smoke detector/ carbon dioxide detector was placed next to wall near the furnace by the administrator on May 23, 2024.
-It was determined that the smoke detector/CO2 detector had been removed by staff for battery and had not been replaced.
-A list of the battery-operated smoke detectors/CO2 detectors was added to the monthly check list to prevent this from occurring. The check list is completed by the 7-3 direct care staff member on the first day of each month is responsible for the completion of the check list. This addition will be reviewed with staff at the June 14th staff meeting by the administrator.
- The monthly checklist was updated by the administrator
- The new monthly checklist will be implemented beginning July 1, 2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

19 - Review Waiver

2. Requirements

2600.
19.f. The Department will review waivers annually to determine compliance with the conditions required by the waiver. The Department may revoke the waiver if the conditions required by the waiver are not met.

Description of Violation

On 11/8/2021, the home received a waiver of 55 Pa. Code § 2600.101(a), granted due to bedrooms #1 through #16 being 76 square feet. The waiver required documentation to be kept for current and future residents of rooms #1 through #16 that they have been informed that the room does not meet the required square footage, but that they choose to reside in that room. Per the home's administrator, Resident #1 moved into bedroom #16 in 2023. The home failed to inform the resident of the waiver applicable to this room, rendering them less living space than 55 Pa. Code § 2600.101(a) requires.

Plan of Correction ***Directed (- 07/01/2024)***

-Resident was initially placed in Room a non-waiver room on admission 2023). In 2023 family requested that resident be placed in the available Room (a room covered by the waiver).
-On 5/22/24 administrator reviewed the waiver with the resident and resident signed the waiver. On 5/23/24 administrator verbally notified resident's whom is POA, that the waiver was reviewed with the resident and that the resident signed the room size waiver. Due to a medical condition, resident has limited awareness of time/place so administrator reviews all paperwork with POA. POA had no objections or questions.
- To correct, starting immediately, the administrator will review this waiver with all new residents, even if it does

19 - Review Waiver (continued)

not currently apply to the room of admission. Administrator will have the resident sign the waiver acknowledgement form after review. If a room change request is made after admission, the resident and POA if applicable, will be aware of the room size waiver for rooms 1-16 prior to the change.
- An audit of resident records in rooms 1-16 was completed by a direct care staff member and administrator. All waivers were in all resident records.
- The process will be implemented by the administrator immediately.

Proposed Overall Completion Date: 06/25/2024

(Directed)
In addition to the above:

- *An audit of resident records in rooms 1-16 was completed by a direct care staff member and administrator by 6/30/24. All waivers were in all resident records*
- *Beginning 6/30/24, the administrator will review this waiver with all new residents, even if it does not currently apply to the room of admission. Administrator will have the resident sign the waiver acknowledgement form after review. If a room change request is made after admission, the resident and POA if applicable, will be aware of the room size waiver for rooms 1-16 prior to the change.*

Directed Completion Date: *07/01/2024*

Implemented (- 09/23/2024)

25b - Contract Signatures

3. 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

The resident-home contract, dated , for Resident #1 was not signed by the resident. The contract did not include a statement that the resident refused to sign the contract.

Plan of Correction ***Accept (- 07/01/2024)***

- Due to limited cognitive abilities the contract was reviewed and signed by resident's POA.
-On 5/22/24 administrator had resident sign the contract which was in agreement to do so. On 5/23/24, administrator verbally notified resident's POA that it was required that the resident signed the contract on 5/22. POA had no concerns or questions.
-Starting immediately for any new admissions administrator will have resident sign the contract or will document a refusal by the resident if applicable.
-On 6/25/24 the administrator and direct care staff member reviewed all resident contracts and confirmed all resident contracts are signed or inability to sign noted.
- Starting July1, 2024 the administrator will use the resident checklist to review any new contracts within one week from admission.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

25g - Admission Contract Copies

4. Requirements

2600.
25.g. A copy of the signed admission contract shall be given to the resident and a copy shall be filed in the resident's record.

Description of Violation

Per staff interview, a copy of the [redacted] resident-home contract for Resident #1 was not given to the resident.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

-Upon admission on 1/25/23, the resident's POA was given the copy of the resident-home contract and the original contract was filed in the resident's record. POA stated resident did not need a copy due to cognitive limitations but that was not documented as such.
- On 5/22/24 administrator offered to resident a copy of the contract and [redacted] refused a copy which was documented on the contract. On 5/23/24 the administrator verbally notified resident's POA that [redacted] refused a copy [redacted] verbalized no concerns and denied the need for a new copy.
- Beginning 5/24/24 , the administrator will document if a resident refuses a copy of the contract and to whom a copy of the contract is given if other than the resident.

Licensee's Proposed Overall Completion Date: *06/26/2024*

Implemented ([redacted] - 09/24/2024)

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 member A, hired on [redacted], does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

-On 5/22/24 staff member was notified by administrator that a copy of [redacted] diploma was needed. Staff member did not have a copy of [redacted] diploma and [redacted] contacted [redacted] school and they are not able to reissue diplomas. Staff member was able to obtain a copy of [redacted] HS transcript. On 5/25/24 staff member presented a copy of [redacted] transcript with a date of graduation noted of [redacted]. Administrator filed a copy of [redacted] transcripts in [redacted] file.
- Administrator will review the current Staff check list of needed staff items prior to the employee's start date beginning 5/25/24 for any new staff hired.
-On 6/25/24 the administrator reviewed the remaining staff records to ensure copy of diploma or GED or PA nurse aid registry.

Licensee's Proposed Overall Completion Date: *06/26/2024*

Implemented ([redacted] - 09/24/2024)

60a - Staff/Support Plan

6. 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

Staff Member D has not successfully completed the Department approved annual practicum requirements for medication administration and is the only staff member present in the home from [redacted] at least [redacted] per week during the month of May 2024. As a result, the home is unable to provide medication administration services during this time. Residents in the home have physician's orders for scheduled pro re nata (PRN) medications.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

-On 5/25/24 Staff member D's practicum requirements were met and charted by med trainer. On 5/26/24 med trainer organized all medication practicum requirements for all med trained staff members. All med trained staff member's documentation was reviewed. All med trained staff met the practicum requirements for the 2nd quarter as of 6/1/24 and documentation was completed by the med trainer as of 6/1/24.
- On 5/26 the med trainer placed all med training documentation in one folder to assist with organization. All med trained staff became compliant with medication administration requirements on 5/25/24 and all documentation completed 5/26/24.
- The med trainer will keep all med trained staff on the same observation/review schedule to promote organization and to prevent any lapses for qualification. The observations/reviews will be scheduled in advanced by the med trainer so no review or observation will be missed. The training schedule for the remainder of 2024 and proposed schedule for 2025 will be completed by the med trainer by 7/1/24 and posted in med room.
-All 4 direct care staff are med trained. 7/1/24 the med training schedule will be posted in the med room by the administrator. All direct care staff/med trained will be able to view the scheduled upcoming med trainings for a better check and balance system.

Licensee's Proposed Overall Completion Date: *06/29/2024*

Implemented ([redacted] - 09/23/2024)

64c - Annual Training

7. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff member [redacted] the home's administrator, completed only 6 hours of Department-approved training in the 2023 calendar training year.

Plan of Correction ***Accept ([redacted] - 07/01/2024)***

- 5 hours of administrator continuing education have been completed for 2024. Resorces have been located for continuing education for 2024 by the administrator. The train the trainer program was counted for the actual course hours and that was not DHS approved.
- The administrator will schedule possible courses available in July and Aug and any remaining in June 2024.
-The administrator will do a mid-year review in June of each year for completed administrator continuing education hours and document the needed remaining hours for 24 if not completed. July 1 2024 the administrator will

64c - Annual Training (continued)

complete the continuing education hour audit for 2024. The subsequent audits will be completed by the administrator in June of each year.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

65e - 12 Hours Annual Training

8. 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 Cembers C and D received only 2 hours of annual training in the 2023 calendar year training year.

Plan of Correction ***Accept (- 07/01/2024)***

The direct care staff has received the 12 hours of required training as of 6/16/24. The administrator has outlined an additional 12 hours of training for 2024.
- The administrator will schedule training for the remainder of 2024 and a training plan for 2025. The administrator will organize all continuing education in one folder.
- The administrator conducted an audit on 6/16/24 for all staff members' required training hours.
- On 6/18/24 the administrator updated the training plan to account for the additional 12 hours for 2024 training.
- The administrator will audit staff training records for each year biannually in June and November. The new audit system will be implemented by the administrator November 1, 2024.

Licensee's Proposed Overall Completion Date: *11/01/2024*

Implemented (- 09/24/2024)

81b - Resident Personal Equipment

9. 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

At 10:05 am Resident #3 had uncovered, split bed rails on the right side of their hospital bed. The opening between the split rails was approximately 6-8 inches, posing an entrapment risk.

At 10:08 am Resident #2's bed had an uncovered, unsecured enabler bar on their bed. The opening was approximately 10" X 5", posing an entrapment risk.

Plan of Correction ***Directed (- 07/01/2024)***

-on 5/22/24 the direct staff member placed a covering over the rails.
- 5/23/24 when checking - Resident #2 had removed the covering. the administrator at that time educated the resident that the covering must stay in place. Resident verbalized understanding. An alternative covering was placed by the administrator on 6/1/24.
- The administrator reviewed with direct care staff at the 6/14/24 staff meeting, that the covering must be kept in

81b - Resident Personal Equipment (continued)

place and to check during the resident's daily bed care that the resident has not removed the covering.
Resident # 3 has been issued a 30 day notice by the administrator
- The administrator audited the 2 residents currently using enablers/rales on 6/20/24.
- On 7/1/24 the administrator will have the direct care staff initial a daily sign off sheet indicating daily check of any enabler bars/rales being used.

Proposed Overall Completion Date: 07/01/2024

(Directed)
In addition to the above, Resident #3's rails will be removed to remain in compliance with approved enabler/bed rails. At lease one rail on the resident's bed will be removed no later than 7/5/24.

Directed Completion Date: *07/05/2024*

Implemented (█ - 09/23/2024)

91 - Telephone Numbers

10. 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

Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were not posted on or by the telephone in the kitchen breezeway entrance.

Plan of Correction ***Accept (█ - 07/01/2024)***

-On 5/22/24 the phone in question was moved by the administrator to the DCS desk. This phone is the extra handset/charging dock. All emergency numbers are posted at the DCS desk.
-The administrator added a power strip 5/23/24 at the DCS desk to provide more electrical outlets so the base is able to be plugged in at the desk.
- The administrator addressed all staff at the 6/14/2024 staff meeting that the base must be kept at the DCS desk. The administrator reviewed with staff as well regulation 2600.91 informing them that emergency numbers must be posted at all phones.
-The administrator informed staff at the 6/14/24 staff meeting that the extra charging base and hand-set need to be stationed and not moved.
-on 6/25/24 the administrator confirmed that the emergency numbers are posted at the 2 phone bases/chargers/handsets.
-Beginning on July 1, 24 the administrator will add Emergency phone Numbers posted to all phones to the monthly checklist.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (█ - 09/24/2024)

94b - Non-Skid Surface

11. Requirements

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

Approximately 15 wooden steps leading into the basement, and used by residents and staff, were not equipped with non-skid surfaces. The wooden steps were finished with a smooth varnish.

Plan of Correction ***Accept (- 07/01/2024)***

-On 6/23/24 the administrator ordered non-skid, reflective step tape to place on basement steps.
- Tape was delivered on 5/30/24. on 5/31/24 administrator applied the non-skid tape to the basement stairs. All other interior and exterior steps in the facility have non-skid surfaces as observed by the administrator on 5/31/24.
-Beginning on 7/1/24 the administrator will add the stair surfaces to the monthly checklist to be assessed which is completed by the administrator.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

12. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There is no grab bar, hand rail or assist bar in the bathroom located in the older, original part of the building.

Plan of Correction ***Accept (- 07/01/2024)***

-On 5/24/24 Administrator scheduled to have the grab bar installed in the recent remodel. This shower had not been in use since while grab bar was not in place. -On 6/1/24 the grab bar was installed by a hired contractor.
- The administrator audited the bathrooms 6/20/24 for grab bars and slip resistant surfaces for showers.
-The administrator will complete an inspection to ensure all requirements are met after any remodel project prior to clearance for resident usage beginning 7/1/24 to ensure all requirements are met.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

103i - Outdated Food

13. Requirements

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

Description of Violation

On 5/22/23, at approximately 10:15am, there was a rotting apple inside a bag of apples to be served.

Repeated Violation - 11/22/22.

103i - Outdated Food *(continued)*

Plan of Correction ***Accept (█ - 07/01/2024)***

- The entire bag of apples which included one apple spoiling was removed 5/22/23 from the storage area in the basement and discarded by direct care staff member.
- At the staff meeting on 6/14/24 which included the cooks, the administrator discussed the 2600.103.i. violation. It was reviewed that as they are in storage area daily that they must discard any dented cans or food that may be spoiling. Also discussed was the need to daily check the refrigerators for dated/labeled food and discard any dated beyond 3 days as well as to check the expiration dates of refrigerator contents- all expired foods are to be discarded. Understanding was verbalized by both cooks.
-Administrator implemented the procedure 6/14/24 that all fruits are to be stored in the kitchen storage. The only perishable food that is able to be stored in the basement is potatoes. On 6/14/24 the administrator posted a sign in the basement storage with this written procedure.
7/1/24 the administrator will place a daily checklist for the cooks to initial daily that they have inspected food areas.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (█ - 09/24/2024)

121a - Unobstructed Egress

14. 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 5/22/23 at 9:10am, a door was blocking the egress route from the home's interior hallway into the social room, and in the direct egress path to exit the building. The door was not equipped with an interior door handle to swing the door into the hallway, which was the only way the door opened completely. The door required full body weight with force to push the door open into the social room approximately 1-2 inches. Per staff interviews, this door is kept closed, blocking the egress route during the winter months.

Repeated Violation - 11/22/22.

Plan of Correction ***Accept (█ - 07/01/2024)***

-On 6/25/24 administrator ordered the needed door pull.
-The door pull/push bars were installed on 6/11/24 by repairman.
- 6/12/24 the administrator applied a reflective EXIT sign on the door to social room. This door is labeled on the Evacuation Plan.
- Staff training on regulations 2600.121 (a) will be conducted by the administrator on 7/2/24 for all staff members.
- July 1, 24 the administrator will include a monthly audit of the egress routes and document on the administrator's monthly check list.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (█ - 09/24/2024)

123c - Evacuation Diagrams

15. Requirements

123c - Evacuation Diagrams *(continued)*

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 18 residents. However, there are no emergency evacuation diagrams posted for the left side of the home, where residents reside in bedrooms #17-20. Additionally, the evacuation diagram posted for the right side of the home, does not include the locations of the smoke detectors and fire alarm pull stations.

Plan of Correction ***Accept (- 07/01/2024)***

- New Evacuation Diagrams were completed by direct care staff on 5/25/24 and posted on both sides of the building that includes the location of the smoke detectors, fire extinguishers, Exit doors and evacuation routes.
-On 5/25/24 residents were informed by direct care worker of new evacuation signs and locations.
- 6/15/24 the administrator added the evacuation plans to the monthly checklist and informed staff at the staff meeting of the additional check for Evac plans to begin 7/1/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

130d - Interconnected Detectors

16. Requirements

2600.
130.d. If the home serves nine or more residents, there shall be at least one smoke detector on each floor interconnected and audible throughout the home or an automatic fire alarm system that is interconnected and audible throughout the home.

Description of Violation

On 5/22/23 at a 10:15am, the home served 18 residents and the basement is not equipped with a smoke detector.

Plan of Correction ***Accept (- 07/01/2024)***

-There is an automatic fire alarm system on the main level of the building. On 5/23/24 the administrator ordered a wired smoke detector. On 6/11/24 the repairman installed the smoke detector in the basement and the administrator confirmed it was in working order.
-The smoke detectors were added by the administrator to the monthly check list that is completed by the direct care staff working the first day of each month. The staff were informed of this addition by the administrator at the staff meeting on 6/14/24.
-The monthly checklist to include the smoke detectors will be implemented on 7/1/24 by direct care staff.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

130h - Inoperable Smoke Detector

17. Requirements

2600.

130h - Inoperable Smoke Detector *(continued)*

130.h. The home’s emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

At the time of the 5/22/24 inspection, the home did not have an inoperable smoke detector policy and the home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction ***Accept (█ - 06/20/2024)***

- The current Emergency Plan includes the procedure for an inoperable smoke detector that has been implemented in the past. On 5/25/24 administrator added the wording "Or Fire Alarms" to the inoperable smoke detector procedure page.
-The administrator developed a policy to address the regulation of 2600.130.h. on 6/1/24. The policy and procedure were reviewed with staff on 6/14/24 by the administrator and the document to record the checks was also reviewed.

Licensee's Proposed Overall Completion Date: *06/15/2024*

Implemented (█ - 09/24/2024)

132c - Fire Drill Records

18. 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 drills conducted monthly from November 2022 to current, 4/30/24, do not include the egress route used. The fire drill records document the exit route used was either, "A, B, C, D, E", or combination of the routes, but the home does not identify on the records or on the doors of the home, which exit route is which.

The fire drill held on 2/25/23 does not record the time of day, with AM or PM, the drill was conducted.

Plan of Correction ***Accept (█ - 07/01/2024)***

-The fire drill record for 2/25/23 was corrected by the administrator on 5/23/24 by writing AM next to the hour and minute on the fire drill record.
- The doors are currently labeled A, B, C, D and E. When the administrator checked the doors on 5/23/24 Doors B, C, D, and E were visible. The door in the social room (fire exit door A) did not have the letter present. The administrator relabeled door A at that time.
- On 5/25/24 the administrator verified that the doors letters were identified on the new evacuation diagrams.
- Door checks have been added by the administrator to the administrator's monthly check list and will be implemented by the administrator on 7/1/24.
- 7/1/24- the administrator will add the fire drill record to the administrator's monthly check list.

Licensee's Proposed Overall Completion Date: *07/01/2024*

132c - Fire Drill Records *(continued)*

Implemented (█ - 09/24/2024)

132d - Evacuation

19. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

- *On 12/6/23 at 1:00pm-total evacuation time was 2 minutes 45 seconds*
- *On 1/5/24 at 8:30am-total evacuation time was 4 minutes.*

Plan of Correction ***Directed (█ - 07/01/2024)***

-On 6/5/24 administrator contacted a local firefighter representative to conduct another supervised fire drill and perform another inspection to address the concerns since the last inspection on 12/5/23. A supervised drill and inspection is scheduled for 6/18/24.
-The administrator will investigate and document such for any fire drill with an evacuation time greater than 2 min 30 sec. including any education or correction needed beginning with the July fire drill.

(Directed)

- *On 6/5/24 administrator contacted a local firefighter representative to conduct another supervised fire drill and perform another inspection to address the concerns since the last inspection on 12/5/23. A supervised drill and inspection is scheduled for 6/18/24.*
- *Beginning 7/1/24, the Administrator or designee will review any problems encountered during a fire drill that may have caused an evacuation time to exceed 2 minutes 30 seconds. The home will address any needs the resident(s) may have in order to evacuate safely and/or education needed.*
- *Residents and staff will receive education on their roles during fire drills to ensure residents can safely evacuate within the required time. Education will be provided by the Administrator or designee no later than 7/10/24.*

Directed Completion Date: *07/10/2024*

Implemented (█ - 09/24/2024)

132e - Fire Drill Sleeping Hours

20. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

At the time of the 5/22/24 inspection, the home has not completed a fire drill during sleeping hours since before

132e - Fire Drill Sleeping Hours (continued)

November 2022.

Plan of Correction ***Accept (- 07/01/2024)***

-The supervised fire drill on 12/5/23 at 9:30 PM was added to the fire drill log by the administrator on 5/23/24.
-The designated fire rep was scheduled by the administrator on 6/1/24 to perform another inspection and night drill on 6/18/24.
- 6/25/24 the administrator reviewed RCG for 2600.132 (e)
-The administrator will implement 7/1/24 a schedule for unannounced fire drills on the monthly checklist to ensure a fire drill is held during sleeping hours as least every 6 months.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

132h - Designated Meeting Place

21. 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 drills on 12/6/23 at 1:00pm, 1/5/24 at 8:30am, 2/8/24 at 4:00pm, 3/29/24 at 12:00pm, and 4/30/24 at 7:00am, Resident #3 was not evacuated to a designated meeting place away from the building or within the fire-safe area. The home documents an additional resident refused to evacuate the home during the 1/5/24 fire drill.

Plan of Correction ***Accept (- 07/01/2024)***

- Resident #3 is a hospice resident. An order had been received by PCP to exclude from participating in a fire drill. Upon notification at inspection on 5/22/24 that there was not proper documentation to exclude resident #3 from fire drills the administrator immediately gave written notification on 5/22/24 to staff that resident #3 would have to be included in fire drills. On 5/23/24 the resident was evacuated to the meeting area by staff within 1 min and 30 seconds without incident.
- At the June town meeting on 6/18/24 the residents will be notified by the administrator of the house rule addition stating that any resident refusing to participate in a fire drill will be issued a 30 day notice. This new house rule will go in to affect beginning 7/18/24. The administrator will give the residents a copy of the new house rules on 6/18/24.
- 7/2/24 the administrator will train all staff members on the need to evacuate during a fire drill.

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

Implemented (- 09/24/2024)

133.1 - Exit Signs

22. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

133.1 - Exit Signs *(continued)*

Description of Violation

A sign bearing the word exit, is placed above the door that leads from the hallway into the social room and its indicated on the home's evacuation diagram as part of the egress route for evacuation. However, the home has another handwritten sign taped to the door that reads, "Do not open not an exit." The door leads directly to the exit door of the building. The home currently serves 18 residents.

Plan of Correction ***Accept (- 07/01/2024)***

-On 5/22/24 a direct staff member immediately removed the sign posted on the door.
-The administrator placed an additional Exit sign on the back of the door 6/1/24 (side facing the hallway) that enters the social room. The door is clearly labeled as an exit in the case that the door becomes closed.
-The administrator did an audit on all exits to ensure there is a proper "Exit" sign posted on 6/1/24.
- The administrator added Exit sign checks to the administrator's monthly checklist on 6/25/24 to be implemented 7/1/24

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

141b1 - Annual Medical Evaluation

23. Requirements

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

Description of Violation

At the time of the 5/22/24 inspection, Resident #1's most recent medical evaluation was completed on

Repeated Violation - 11/22/22.

Plan of Correction ***Accept (- 07/01/2024)***

-The administrator's designee present during PCP visits noticed on 5/21/24 that resident's DME was due in and had the PCP complete the physical on 5/21/24. A to indicate the month of was mistaken for a The DCS member corrected immediately once discovered on 5/21/24. When filing the DME in the resident's record a mistake was discovered and the PCP was notified by the DCS member on 5/22/24. The correct form was faxed to the facility on 5/22/24 and presented to inspectors.
- The administrator developed a new tracking system with a start date of 6/12/24 for physicals and RASP due dates where the month is to be written not designated with a number to prevent mixing the numbers. The information was transferred to the new system by the direct care staff member and reviewed by the administrator on 6/12/24. A copy was given to the administrator as a second check to plan for upcoming renewals.
- Direct care staff member will review this list on the first of each month beginning 7/1/24.
-The administrator will review the list the first day of the month as a second check beginning 7/1/24

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/24/2024)

162c - Menus Posted

24. Requirements

162c - Menus Posted *(continued)*

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The menu for the current week was posted. However, the menu posted for 1 week in advance did not include breakfast from 5/28/24 through 6/1/24, or lunch and dinner for 6/1/24.

Plan of Correction ***Accept (- 07/01/2024)***

- On 5/23/24 the cook completed the menu to include June 1st. July's breakfast, lunch and dinner menus were completed on 5/23/24 and posted.
-on 6/14/24 staff meeting, the administrator informed the cooks that the menu for the following month must be completed and posted by the 15th day of each month and any discovered omission must be corrected immediately. This is the responsibility of the cook.
- On 6/15/24 the administrator confirmed that the July menu is posted.
- Beginning 7/15/ 24 the cooks will initial beside the 15th day of the menu that they are confirming the next month's menu is posted.

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

Implemented (- 09/24/2024)

183b - Meds and Syringes Locked

25. 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.

Description of Violation

On 5/22/24 at approximately 4:00pm, Resident #1's glucose gel was unlocked, unattended, and accessible in a staff's rolling cart in the dining room.

Plan of Correction ***Accept (- 07/01/2024)***

-On 5/22/24 the staff member removed the glucose gel from cart and observed the cart for any medication, no other medication was found.
- At the 6/14/24 staff meeting it was addressed to the staff by the administrator that no medication can be stored including glucose gel on the cart. When not attended or being used, the cart is to be stored in the locked medication room.
-On 6/15/24 the administrator observed the staff locking the cart in the medication room when not attended.
- Direct care staff audited the home to assess for any unlocked medications in any common areas and resident rooms on 5/23/24.
- The administrator will assign the Sunday 3-11 direct care staff to do weekly checks for any unattended medications throughout the home beginning 7/15/24

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

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

Implemented (- 09/24/2024)

183e - Storing Medications

26. 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 5/22/24 at 4:00pm, Resident #1's open, fiasp insulin pen, administered daily to the resident, was stored in the refrigerator. According to the manufacturer's instructions, the medication is to be refrigerated until the first use, then store at room temperature (between 36 and 86 degrees Fahrenheit).

Plan of Correction ***Accept (- 07/01/2024)***

-On 5/22/24 the insulin pen was discarded by direct staff member. The new fiasp pen opened on 5/23/24 for use was placed in medication room to be stored. On 5/23/24 DCS member reviewed all medication manufactures, storage instructions to ensure compliance. A note was place in the medication room on the medication refrigerator as a reminder of the insulin that needs to be stored at room temperature after opening.
-The staff were verbally notified by administrator on 5/23/24 of the manufactures' instructions and that the manufactures' storage instructions are read on every new medication if not indicated by the pharmacy and stored as such.
-The med trainer has a training scheduled for all med techs 6/28/24 to review the procedures for compliance.
- Starting 6/15/24 all new medications are assessed for storage recommendations by the direct staff member receiving the medication(s) and stored in the proper location. Any special instructions will be written/noted by the receiving direct care staff member in the medication room to notify all staff.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (- 09/24/2024)

184a - Resident's Meds Labeled

27. 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

The pharmacy label for Resident #1's glucose gel does not include the prescribed dose and administration instructions.

Plan of Correction ***Accept (- 06/21/2024)***

- On 5/23/24 DCS member contacted the pharmacy to request specific instructions for the glucose gel. The

184a - Resident's Meds Labeled (continued)

pharmacy stated an order was needed. Same DCS contacted PCP office that we needed an updated order faxed to us and the pharmacy. On 5/28/24 an order was received by PCP stating that "the above patient is to be given glucose gel if blood sugar is 70 or less. Order also sent by PCP to pharmacy for updated label.
- Upon medication review by med trainer/RN 6/13/24 it was determined that the order needed to be clarified to designate with or without symptoms and if it is to be readministered if needed. RN contacted PCP office on 6/13/24 for order clarification for glucose gel administration. A clarified order was faxed on 6/13/24 to the facility and the pharmacy. The new label is to be sent by the pharmacy for resident's glucose gel with the clarified instructions.
-New procedure determined on 6/13/24 that a copy of any new order will be reviewed by the RN to determine if order is a complete order to ensure that the pharmacy labels are correct as well. Med techs verbally informed of this procedure 6/13/24.
- Med trainer will review label requirements at the Med update training for all med techs 6/28/23.
-Label

Licensee's Proposed Overall Completion Date: *06/28/2024*

Implemented (█ - 09/23/2024)

186a - Authorized Prescriber

28. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

Resident #1 had glucose gel, with instructions to use as directed, on the medication label. At the time of the inspection, the home did not have the written physician's instructions for administration.

Resident #1 is prescribed fiasp insulin, inject 2 units if blood sugar is between 120-150, 5 units if blood sugar is between 151-200, and 8 units if blood sugar is over 201. Staff are checking the resident's blood sugar 4 times a day, 7am, 11am, 4pm, and 8pm, but never administering the sliding scale prescribed for fiasp to Resident #1 for the 8pm blood sugar check. At the time of the 5/22/24 the home did not have physician's order to only administer the sliding scale at mealtimes; 7am, 11am, and 4pm.

Plan of Correction ***Accept (█ - 07/01/2024)***

- On 5/23/24 direct care staff member contacted resident's PCP for written instructions for the glucose gel administration and an updated sliding scale order. Resident's PCP faxed an order 5/28/24 stating, "The above patient is to be given glucose gel if blood sugar is 70 or less". On 6/13/24 RN reviewed order and contacted PCP to provide clarification of when additional glucose gel could be administered and amount. On 6/13/24 an updated order was received as "31gm (one pouch) by mouth as needed if blood sugar is 70 or less and lethargic administer 31 gm by mouth, recheck blood sugar 15 minutes after and may need to repeat until blood sugar is above 70". On 6/3/24 an updated order to check BS three times a day at (7, 11, 4) and an updated sliding scale. On 6/13/24 RN reviewed sliding scale and contacted PCP office to clarify "check b15 ML". On 6/13/24 an updated order was faxed to facility.
- As of 6/13/24 all orders will be reviewed by RN to determine if orders are complete.
- Med techs will be receiving training by the med trainer on 6/28/24 to review what a complete order is.
- An audit for all medications was performed by direct care staff members. All written orders were stored in the resident's MAR book which is where all current medication orders will be stored for easy access. The audit was completed 6/15/24.

186a - Authorized Prescriber (continued)

-As of 6/15/24 all new medication orders or d/c orders are obtained by the direct care staff on duty when the medication change occurred. All med techs were trained on this new procedure by the med trainer on 6/28/24.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (█ - 09/24/2024)

187a - Medication Record

29. Requirements

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

1. Resident’s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1 is prescribed fiasp insulin, inject 2 units if blood sugar is between 120-150, 5 units if blood sugar is between 151-200, and 8 units if blood sugar is over 201. Resident #1's medication administration record (mar) does not indicate the time of administration for the doses of fiasp administered to the resident on May 4th-6th, 9th-10th, 12th-13th, and 15th-18th.

Resident #1 has an order for glucose gel; however, this medication is not on the May 2024 medication administration record.

Plan of Correction ***Accept (█ - 07/01/2024)***

- On 5/28/24 the glucose gel was written on the MAR by the direct care staff member after an updated order was obtained. On 6/13/24 the updated order was written on the MAR by the direct care staff member.
- ON 5/28/24 the insulin order was received and added to the MAR by the direct care staff member.
- The med trainer has scheduled a medication administration update for all med techs. on 6/28/24
- By 6/15/24 all orders and MARs were audited by direct care staff member
- Beginning 7/1/24 Direct Care Staff member will check the MARs monthly and confirm all mediations are documented. The direct care staff member will contact the PCP of the resident in question for any found discrepancies and obtain any need written orders and corrections. This MAR check will be documented on a sheet located in the MAR book by the direct care staff member completing.

187a - Medication Record *(continued)*

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (█ - 09/23/2024)

187d - Follow Prescriber's Orders

30. Requirements

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

Description of Violation

Resident #1 is prescribed metoprolol, take ½ tablet by mouth every day and hold if systolic blood pressure (top/first number) is below 100. However, Resident #1 was administered metoprolol on 5/12/24 and 5/4/24 at 8am when their systolic blood pressure reading was 66 and 69, respectively. Additionally, Resident #1's blood pressure logs do not indicate the time the resident's blood pressure is obtained to indicate if staff are administering or holding the resident's metoprolol as prescribed.

Resident #1 is prescribed fiasp insulin, inject 2 units if blood sugar is between 120-150, 5 units if blood sugar is between 151-200, and 8 units if blood sugar is over 201. On the following occasions, Resident #1's fiasp insulin was not administered as prescribed:

Date/time	Blood sugar/glucose reading	Units of fiasp administered
5/4/24, 4pm	142	0
5/20/24, 4pm	133	0
5/20/24, 11am	122	0
5/19/24, 4pm	120	0
5/17/24, 4pm	162	illegible and/or zero, as it was only administered once on 5/17/24
5/17/24, 11am	195	illegible and/or zero, as it was only administered once on 5/17/24
5/16/24, 4pm	175	0
5/15/24, 4pm	136	0
5/13/24, 4pm	129	0
5/11/24, 4pm	153	0
5/10/24, 7am	120	0

Resident #2 is ordered calcitonin-salmon nasal spray, use 1 spray in alternating nostril every day. Per staff interviews, this medication was opened and used starting 2/1/24. According to the manufacture's packaging, the medication bottle only contained 30 doses. At the time of the 5/22/24 inspection, the nasal spray bottle was approximately 90% full.

Plan of Correction ***Accept (█ - 07/01/2024)***

-As of 5/23/24 all nasal sprays are administered by the med tech to know resident is receiving the nasal spray.
- On 5/23/24 the direct care staff member contacted resident's PCP for an updated order for resident's sliding scale. On 5/28/24 an updated order was received.
- On 5/24/23 administrator developed a new BP log for the resident that includes Date, time, reading, initials and area to acknowledge if medication had been held per the order and put into use- staff notified by administrator.

187d - Follow Prescriber's Orders (continued)

-On 6/1/24 all medications and MARs were reviewed by direct care staff to identify any discrepancies on MAR/Order.
- Med trainer has a scheduled training for all med techs on 6/28/24
-Beginning 7/1/24 the direct care staff member will be completing monthly MAR checks to ensure the label, MAR and medication order match. This audit will be documented on a sheet in the MAR book by the direct care staff member completing the audit.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (█ - 09/23/2024)

190a - Completion Medication Course

31. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member C has not successfully completed the Department approved annual practicum requirements for medication administration as evidenced by MAR reviews last completed in November 2022 and February 2023 and only one observation last completed in February 2023. The annual practicum documentation does not indicate if Staff Member C was recertified and does not include the trainer's signature or date. Staff Member C administered medications as follows:
On 5/18-21/2024 at 8am, toujeo solostar insulin to Resident #1.
On 5/1-8/2024, fiasp insulin injection to Resident #1.
On 5/14-16/2024 at 8am, escitalopram 10mg to Resident #2.

Staff member E has not successfully completed the Department approved annual practicum requirements for medication administration as evidenced by only one MAR review and observation last completed in February 2023. The annual practicum documentation does not indicate if Staff Member E was recertified and does not include the trainer's signature or date. Staff Member E administered medications as follows:
On 5/11-13/2024 at 8am, oxybutynin 10mg to Resident #2.
On 5/18-19/2024 at 4pm, furosemide 20mg to Resident #2.
On 5/17/24 at 8am, metoprolol to Resident #1.

Plan of Correction ***Accept (█ - 07/01/2024)***

- All medication observations and training information was organized into one folder for better tracking 6/1/24. All med techs staff member E and C s documentation was identified by administrator and all med techs requirements were met by 6/1/24
-On 6/1/24 all information was organized by administrator and all med tech training records were completed after reviews by the med trainer.
- Beginning 7/1/24 the med trainer will audit the med tech certifications quarterly to ensure all trainings, certifications, and documentation is completed.

Licensee's Proposed Overall Completion Date: *07/01/2024*

190a - Completion Medication Course *(continued)*

Implemented (█ - 09/23/2024)

191 - Resident Right to Refuse

32. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted █, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (█ - 07/01/2024)***

-Resident # 1 had cognitive decline. On █ the date of resident's admission █ was present when the contract was reviewed with █ POA by the administrator. Resident rights, house rules, phone numbers, the complaint process, inventory, extra fees are explained to the resident by the administrator during this time. Resident rights are also displayed on the information board located in the dining room.
- the administrator had the resident's POA acknowledged that the resident rights were reviewed with the resident and POA at admission.
- The resident's rights are reviewed upon admission and is included in the admission packet with the contract. Starting 6/15/24 the administrator has the resident initial the resident right sheet to document acknowledgement of the review. The administrator educates the resident of the right to refuse medication if unsure of an error during this time.
-The administrator will conduct an audit of all resident records and ensure that each resident understands that they have the right to refuse medication if they believe there is an error and have the resident sign a document and file in each resident's record by 7/15/24.

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

Implemented (█ - 09/24/2024)

202 - Prohibitions

33. Requirements

2600.
202. The following procedures are prohibited:
  5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.

Description of Violation

On 5/22/24 at approximately 10:05am, Resident #3's hospital bed was equipped with two-half rails, or split bed rails on the right side of their bed. Staff members C and B reported to the Department that Resident #3 cannot operate the bedrails. At approximately 5:30pm Staff member B reported to the Department the bed rails are on the bed to keep Resident #3 from getting out of bed, that the resident needs full staff assistance to transfer in and out of bed and ambulate, and that staff can not physically be in the resident's room at all times so the bed rails were ordered and

202 - Prohibitions (continued)

placed to keep the resident from being able to get out of bed.

Plan of Correction ***Directed (- 07/01/2024)***

- The bed rails were placed by hospice after resident was crawling out of bed. Resident's health declined after an acute illness in The administrator discussed with resident's POA and Hospice social worker that resident's needs were advancing and the resident needed other placement. Resident has been on waiting list for several skilled facilities since
- 6/13/24 the administrator informed hospice that a 30 day notice was given to resident's POA. Hospice aware that bed rails cannot be in place.
- An audit was conducted by the administrator on 6/20/24 on all resident rails/enablers.
-The administrator reviewed regulation 2600.202 on 6/25/24.

Proposed Overall Completion Date: 06/30/2024

(Directed)
In addition to the above, Resident #3's rails will be removed to remain in compliance with approved enabler/bed rails. At lease one rail on the resident's bed will be removed no later than 7/5/24.

Directed Completion Date: *07/05/2024*

Implemented (- 09/24/2024)

227d - Support Plan Medical/Dental

34. 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 #3 uses a hospital bed equipped with two-half rails, or split bed rails on the right side of their bed. Resident #3's current resident assessment and support plan, dated , does not document the specific need for the devices, the intended use and any risks associated with the use, the resident's ability to use the device safely or for the purpose it was intended, the identification of the specific device to be used and whether a cover is required.

Resident #2 uses an enabler bar at bedside. The resident's current resident assessment and support plan, dated , does not document the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely or for the purpose it was intended, the identification of the specific device to be used and whether a cover is required.

Plan of Correction ***Accept (- 07/01/2024)***

- New RASP were completed by the administrator on 6/3/24 to include all needed information.

227d - Support Plan Medical/Dental (continued)

- All RASP will be updated by the administrator at the time of the change.
- Direct care staff member will assist the administrator with review/audit of all RASPs for each resident by 7/15/24 to ensure all current needs are documented. Any updates/changes will be made by 7/15/24 by the administrator.
- Direct care staff will note any significant changes noted during the monthly PCP visit and update the RASP with any necessary changes and alert the administrator of these changes. This system will be implemented when the PCP is scheduled 7/16/23. If any resident's have another PCP the direct care staff will review the medical documentation and note any significant changes. The DCS member will notify the administrator of such changes and the administrator will update the RASP with any necessary changes.

Licensee's Proposed Overall Completion Date: *07/16/2024*

Implemented (█ - 09/24/2024)