pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LAFAYETTE MANOR INC LMI**
LEGAL ENTITY

To operate **BEECHWOOD COURT AT LAFAYETTE MANOR**
NAME OF FACILITY OR AGENCY

Located at **145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA 15401**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **64**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 23**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 13,** **2024** until **June 13,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **409611**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 16, 2025
REVISED

[redacted], Administrator
Lafayette Manor Inc LMI
145 Lafayette Manor Road
Uniontown, Pennsylvania 15401

RE: Beechwood Court at LaFayette Manor
License/COC #: 409611

Dear [redacted]:

This letter rescinds and replaces the prior letter, dated 12/13/2024, due to pages that were omitted from the original enforcement packet.

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 13, 2024, June 14, 2024, August 29, 2024, October 1, 2024, and October 3, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), mistreatment or abuse of resident being cared for in the facility, failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 409610) dated September 21, 2024 – September 21, 2025, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code §20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 13, 2024 to June 13, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted] Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *BEECHWOOD COURT AT LAFAYETTE MANOR* **License #:** *40961* **License Expiration:** *09/21/2024*

Address: *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA 15401*

County: *FAYETTE* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *LAFAYETTE MANOR INC LMI*

Address: *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA, 15401*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/27/2000* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *66* **Waking Staff:** *50*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *06/14/2024*

Inspection Dates and Department Representative

06/13/2024 - On-Site: [redacted]

06/14/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served:** *51*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st floor* **Capacity:** *23* **Residents Served:** *15*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *51*

Diagnosed with Mental Illness: *15*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *15*

Have Physical Disability: *3*

Inspections / Reviews

06/13/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/21/2024*

07/22/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/26/2024*

07/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/01/2024*

11/18/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 6/13/24, the license inspection summary, dated 6/29/22, et. al., was not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed (- 07/24/2024)***

Administrator printed license inspection summary and posted in a conspicuous and public place on 6/17/2024. Administrator educated by direct supervisor on license inspection summary posting and regulation 3c on 7/9/2024. Administration or Administrative assistant will audit monthly starting on 7/22/24 to ensure license inspection summary postings are posted per regulation 3c. (DIRECTED: The monthly audits shall also include ensuring all other items specified in 2600.3c are posted in a public and conspicuous place in the home. 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

5a1 - DHS Access

2. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 6/13/24 at 9:15 AM, an agent of the Department requested a current resident list with dates of admission and resident #1's resident record; however, the list of residents with dates of admission was not provided to the agent of the Department until 11:06 AM, and resident #1's record was not provided to the agent of the Department until 12:09 PM.

Plan of Correction ***Accept (- 07/24/2024)***

Administrator will educate alternate staff on how to access information requested by Agents of the Department in the Administrators absence and regulation 5a1 at staff training to be held on 7/30/2024. Alternate staff members are designated to ensure 1 designated staff member is in the building at all times to provide information requested by Agents of the Department including all staff/resident records. Administrator will ensure new staff are trained accordingly to ensure accessibility at all times. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented (- 11/18/2024)

17 - Record Confidentiality

3. Requirements

17 - Record Confidentiality *(continued)*

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 6/13/24 at 10:55 AM, approximately 50 resident binders containing resident medical information were unlocked, unattended and accessible on the shelving unit in the secured dementia care unit (SDCU) nurses' station.

On 6/14/24 at 9:00 AM, the records for residents #1, #2, #3, #4, and #5 were unlocked, unattended and accessible in the administrator's office.

REPEAT VIOLATION: 6/29/2022, et. al.

Plan of Correction ***Accept ([redacted] - 07/24/2024)***

On 6/14/2024 at approximately 5pm Wellness Director secured previously unsecured charts. Administrator re-educated Wellness Director on record confidentiality. Administrator will hold staff training on 7/30/24 to educate all staff on regulation 17-Record Confidentiality. Documentation of the staff education will be kept in accordance with 2600.65i. Administrator or Administrative assistant will perform audits weekly x 4 weeks starting the 7/22/241 and then monthly to ensure record confidentiality throughout the building. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 11/18/2024)

51 - Criminal Background Check

4. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

No Pennsylvania criminal background check was completed for direct care staff person A, who was hired on [redacted]

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Staff person A's Pennsylvania criminal background check was completed by Human Resources Director on 7/16/24. Human Resources Director and Administrator were educated on 7/17/24 by direct supervisor on regulation 51-Criminal Background Checks. New Hire checklist was implemented on 7/23/24 and HR Director and Administrator were educated on 7/23/24 by direct supervisor. (DIRECTED: Copies of all completed new hire checklists shall be kept in each staff person's record. [redacted] 7/24/24). All educations will be kept in accordance with 2600.65i. Employee personnel files of new hires within the last month will be audited by Human Resources Director for Pennsylvania Criminal Background Checks. (DIRECTED: By 8/5/24: The Human Resource Director shall review all current staff person records to ensure a Pennsylvania criminal background check has been completed for each staff person. [redacted] 7/24/24). Human Resources Director will perform audits beginning 8/1/24 monthly x3 months to verify Pennsylvania criminal background checks are performed prior to new employee start of employment. QM meeting

51 - Criminal Background Check (continued)

scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/14/2024

Directed Completion Date: *08/13/2024*

Implemented ([redacted] - 11/18/2024)

63a - First Aid/CPR Training

5. Requirements

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

Description of Violation

On the following dates and times, there were no staff persons present in the home who were currently trained in first aid and certified in obstructed airway techniques and CPR:

- *On 6/13/24 from approximately 10:30 PM through 6:00 AM on 6/14/24. During this time, the home served 50 residents*
- *On 6/12/24 from approximately 10:30PM through 6:00 AM on 6/13/24. During this time, the home served 50 residents*
- *On 6/5/24 from approximately 10:30 PM through 6:00 AM on 6/6/24. During this time, the home served 51 residents*
- *On 6/4/24 from approximately 10:30 PM through 6:00 AM on 6/5/24. During this time, the home served 51 residents*

Plan of Correction ***Accept ([redacted] - 07/25/2024)***

Administrator performed audit on staff persons CPR, first aide and obstructive airway techniques Training records to identify staff not certified on 7/17/24. 2 staff members trained since survey to ensure compliance on 6/20/24. Additional training scheduled for the week of 7/22/24 to train additional staff members.. Administrator educated on regulation 63a by direct supervisor on 7/17/24. Documentation of the staff education will be kept in accordance with 2600.65i Administrator will develop and implement a tracking system by 8/1/24 on all staff trained and the expiration date. Administrator will perform audit daily to review direct care staffing schedule to ensure compliance with this regulation starting 7/24/24. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 11/18/2024)

65a - FS Orientation 1st Day

6. Requirements

2600.

65a - FS Orientation 1st Day *(continued)*

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person B, hired on [redacted] did not receive orientation on any of the topics specified in 2600.65a.

REPEAT VIOLATION: 6/29/2022, et. al.

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Direct Care staff person B was provided orientation on subjects listed in 65a on 7/18/24. Documentation of staff person B's orientation will be kept in accordance with 2600.65i. New Hire checklist was implemented on 7/23/24 and HR Director and Administrator were educated on 7/23/24 by direct supervisor. (DIRECTED: Copies of all completed new hire checklists shall be kept in each staff person's record. [redacted] 7/24/24). Administrator was educated on regulation 65a FS Orientation 1st Day on 7/17/24 by direct supervisor. All educations will be kept in accordance with 2600.65i. Administrator or HR Director will perform audits on new hire employee personnel files monthly starting 8/1/24 to ensure orientation topics in 65a are completed. Administrator or HR Director will perform audits of new hires within the last 6 months personnel files to ensure orientation was done per 65a by 8/1/24. (DIRECTED: By 8/5/24: The Human Resource Director shall review all current staff person records to ensure each staff person has received orientation on all topics specified in 2600.65a. [redacted] 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Not Implemented ([redacted] - 11/18/2024)

65b - Rights/Abuse 40 Hours

7. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

65b - Rights/Abuse 40 Hours *(continued)*

Description of Violation

Direct care staff person B, hired on [redacted] did not receive orientation on any of the topics specified in 2600.65b.

REPEAT VIOLATION: 6/29/2022, et. al.

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Staff person b was educated on required topics by Administrator on 7/18/24. Staff person B's orientation will be kept in accordance with 2600.65i. All staff members will be educated on the importance of completing initial training educations on time at training scheduled for 7/30/2024. Documentation of the education will be kept in accordance with 2600.65i. New Hire checklist was implemented on 7/23/24 and HR Director and Administrator were educated on 7/23/24 by direct supervisor. (DIRECTED: Copies of all completed new hire checklists shall be kept in each staff person's record. [redacted] 7/24/24). Documentation of the education will be kept in accordance with 2600.65i. Administrator or HR Director will perform audits of new hires within the last 6 months personnel files to ensure orientation was done per 65b by 8/1/24. Administrator or HR Director will perform audits on new hire employee personnel files monthly starting 8/1/24 to ensure orientation topics in 65b are completed. (DIRECTED: By 8/5/24: The Human Resource Director shall review all current staff person records to ensure each staff person has received orientation on all topics specified in 2600.65b. [redacted] 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Not Implemented ([redacted] - 11/18/2024)

65d - Initial Direct Care Training

8. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired on [redacted], has not successfully completed and passed the Department-approved direct care training course and pass the competency test. Direct care staff person B has provided unsupervised ADL services to numerous residents on numerous dates and times.

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Staff person B passed the Department approved direct care training course on 6/14/24. Administrator will audit all personnel files to ensure department approved direct care training course is completed by 8/1/24. Administrator was re-educated on regulation 65d – Initial Direct Care Training by direct supervisor on 7/18/24. Documentation of the education will be kept in accordance with 2600.65i. New Hire checklist was implemented on 7/23/24 and HR Director and Administrator were educated on 7/23/24 by direct supervisor. (DIRECTED: Copies of all completed

65d - Initial Direct Care Training (continued)

new hire checklists shall be kept in each staff person's record. [redacted] 7/24/24). Documentation of the education will be kept in accordance with 2600.65i. Administrator will audit all new hires for completed direct care training weekly x4 weeks them monthly. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented ([redacted] - 11/18/2024)

65f - Training Topics

9. Requirements

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
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 person A, hired on [redacted] did not receive training on any of the topics specified in 2600.65f during the 2023 training year.

Direct care staff person C, hired on [redacted], did not receive training on instruction on meeting the needs of the residents as outlined in preadmission, assessment, medical evaluation and support plan during the 2023 training year.

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Administrator was educated on regulation 65f training topics required yearly for staff by direct supervisor on 7/17/24. Staff person's A and C will be trained by the administrator on missing educations by 8/1/24. Documentation of the education will be kept in accordance with 2600.65i. All staff members will be educated on the importance of completing annual educations on time at training scheduled for 7/30/2024. Administrator or Administrative Assistant shall review all staff training monthly to ensure all direct care staff persons receive training on all topics specified in 2600.65f during each training year. (DIRECTED: The monthly review of staff trainings shall begin on 8/1/24. [redacted] 7/24/24). The home's staff training plan will be reviewed monthly at the QM meetings. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented ([redacted] - 11/18/2024)

65g - Annual Training Content

10. 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:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Direct care staff person A, hired on [redacted], did not receive training on any of the topics specified in 2600.65g during the 2023 training year.

Direct care staff person C, hired on [redacted], did not receive training on the following topics during the 2023 training year:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Falls and accident prevention*

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Administrator was educated on regulation 65g annual training content required yearly for staff on 7/17/24 by direct supervisor. Staff person's A and C will be trained by the administrator on missing educations by 8/1/24. All staff members will be educated on the importance of completing annual educations on time at training scheduled for 7/30/2024. Fire Safety expert visit scheduled for 7/22/24. Documentation of the education will be kept in accordance with 2600.65i. Administrator or Administrative Assistant shall review all staff training monthly to ensure all direct care staff persons receive training on all topics specified in 2600.65g during each training year. (DIRECTED: The monthly review of staff trainings shall begin on 8/1/24 and shall include a review of all staff person trainings to ensure all direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers receive training on all topics specified in 2600.65g during each training year. [redacted] 7/24/24).The home's staff training plan will be reviewed monthly at the QM meetings. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented ([redacted] - 11/18/2024)

88a - Surfaces

11. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 6/13/24, numerous ceiling tiles were stained with large, brown stains to include the following areas:

- *3 ceiling tiles in the basement activity room*

88a - Surfaces (continued)

- *6 ceiling tiles in the private dining room near the administrator's office*

On 6/13/24 at 12:17 PM, there was no doorknob present on the closet door in resident #6's bedroom.

REPEAT VIOLATION: 8/15/2023

Plan of Correction ***Directed (- 07/25/2024)***

Ceiling tiles in basement activities room and private dinning room replaced by maintenance staff on 6/17/24. Door knob on closet door for resident #6 replaced by maintenance staff on 6/17/24. All staff persons shall be re-educated on the home's procedures for reporting issues that need repaired or replaced to ensure compliance with regulation at training session scheduled for 7/30/24 by Administrator. Documentation of the education shall be kept in accordance with 2600.65i. Administrator will audit residents closet doors for handles and building for stained ceiling tile and replace as indicated by 8/1/24. Administrator or Administrative assist will perform audit weekly for 2 months then monthly to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. (DIRECTED: The weekly audits shall begin on 8/1/24. 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

95 - Furniture and Equipment

12. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 6/13/24 at 11:26 AM, the sink drain was clogged at the sink in the private resident dining room, preventing the sink from draining.

Plan of Correction ***Directed (- 07/25/2024)***

Sink drain in resident private dinning room unclogged by maintenance on 6/19/24. All staff persons shall be re-educated on the home's procedures for reporting issues that need repaired or replaced to ensure compliance with regulation at training session scheduled for 7/30/24 by Administrator. Documentation of the education shall be kept in accordance with 2600.65i. Administrator or Administrative assist will perform audit weekly for 2 months then monthly to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. (DIRECTED: The weekly audits shall begin on 8/1/24 and shall include a walkthrough of the entire home to ensure all furniture and equipment is in good repair, clean and free of hazards. . 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the

95 - Furniture and Equipment (continued)

QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

101j7 - Lighting/Operable Lamp

13. Requirements

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

Description of Violation

On 6/13/24 at 12:17 PM, no operable lamp or other source of lighting was present at resident #6's bedside.

On 6/13/24 at 12:37 PM, no operable lamp or other source of lighting was present at resident #7's bedside.

Plan of Correction ***Directed (- 07/25/2024)***

Administrator replaced lamps in resident #6 and resident #7'a rooms on 6/19/24. Administrator performed audit of all residents rooms to ensure a lamp is present by 08/01/24. All staff persons shall be re-educated on regulation 101j7 at training session scheduled for 7/30/24 by Administrator. Documentation of the education shall be kept in accordance with 2600.65i.
Administrator or Administrative assistant will continue audit for lamps being present in 10 residents room monthly ~~x3 months~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. Audits of 10 resident bedrooms each month shall continue. 7/24/24). starting 9/2/24. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Not Implemented (- 11/18/2024)

103g - Storing Food

14. Requirements

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

Description of Violation

On 6/13/24 at 11:31 AM, the following trays of food were uncovered in the Turbo refrigerator in the 1st floor serving kitchen:

- *32 cups of sliced oranges*
- *32 cups of cucumber and tomato salad*

103g - Storing Food (continued)

On 6/13/24 at 11:39 AM, there was an open and unsealed bag of 10 grilled chicken breasts present in the 2nd floor kitchen walk-in freezer.

Plan of Correction ***Directed (- 07/25/2024)***

Cited items were discarded by Chef on 6/13/24. Dietary Director educated kitchen staff on dating and labeling of food on 6/19/24. Dietary Director or Administrator will provide re-education to staff on regulation 103g at training session scheduled for 7/30/24. Documentation of the education will be kept in accordance with 2600.65i. Dietary Director or designee will perform audits randomly weekly x4 weeks then monthly ~~x 3 months~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The monthly audits shall continue monthly. 7/24/24). to ensure proper labeling/dating starting 8/1/2024. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

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 6/13/24 at 11:09 AM, there was debris, plastic bags and 5 long, wooden boards present on the stairs of the external emergency exit route from the basement activity room.

Plan of Correction ***Directed (- 07/25/2024)***

Maintenance removed debris, plastic bags and wood from exit route from the basement activity room on 6/14/24. Administrator educated on regulation 121a on 7/17/24 by direct supervisor. Staff will be re-educated on regulation 121a at training session scheduled for 7/30/24 by Administrator. Documentation of the education will be kept in accordance with 2600.65i. Administrator or administrative assistant will perform audits of all stairways, hallways, doorways, passageways and egress routes from rooms and from the building weekly to ensure they are unlocked and unobstructed. (DIRECTED: The weekly audits shall begin on 8/1/24. 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

131f - Fire Extinguisher Inspection

16. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 6/13/24, the tag on the fire extinguisher, located in the boiler room near the hand washing sink, does not include the date it was inspected, so it is unable to be determined if the fire extinguisher was inspected and approved by a fire safety expert within the past year.

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Boiler room fire extinguisher was re-inspected on 7/19/24 by Safety First Fire Equipment to verify the March annual inspection and tag punched. Maintenance Director performed audit on 7/23/24 on all fire extinguishers in home to verify they were inspected by a fire safety expert within the last year. Administrator or Administrative Assistant will randomly audit 5 fire extinguishers monthly to ensure continued compliance starting 8/1/24. (DIRECTED: By 8/1/24: The administrator shall develop and implement a tracking system to ensure all fire extinguishers are inspected and approved by a fire safety expert annually and to ensure the date of inspection is present on each fire extinguisher. Documentation of the system shall be kept. [redacted] 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented ([redacted] - 11/18/2024)

132a - Monthly Fire Drill

17. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home has not conducted an unannounced fire drill during the months of May 2024, March 2024, January 2024, December 2023, November 2023, October 2023, September 2023, August 2023, July 2023, June 2023 or May 2023.

Numerous staff persons indicated they are notified in advance of fire drills.

Plan of Correction ***Accept ([redacted] - 07/25/2024)***

Unannounced fire drill held on 6/17/24 by Maintenance Director, all documentation completed per regulation. Administrator educated on regulation 132a by direct supervisor on 7/17/24. Re-education was completed with staff members that conduct fire drills on regulation 132a and not notifying staff prior to fire drill on 7/23/24 by direct supervisor. Documentation of the education will be kept in accordance with 2600.65i. Administrator will monitor fire drills monthly starting 7/22/24 to ensure compliance with regulation. QM meeting scheduled for 8/13/2024 which

132a - Monthly Fire Drill (continued)

will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 11/18/2024)

132b - Safety Inspection/Fire Drill

18. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home has no documentation indicating a fire safety inspection and fire drill were conducted by a fire safety expert within the past year.

Plan of Correction ***Accept ([redacted] - 07/25/2024)***

Fire Safety Expert came to building for inspection and fire drill 7/22/24, documentation of the fire safety inspection and supervised fire drill will be kept. Administrator educated on regulation 132b - safety inspection/fire drill by direct supervisor on 7/17/24. Administrator will monitor quarterly to ensure compliance with fire safety inspection and supervised fire drill starting on 10/01/2024. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 11/18/2024)

132c - Fire Drill Records

19. 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 fire drill conducted on 4/13/24 at 9:26 PM does not include the amount of time it took for evacuation. This section of the fire drill record is blank.

The fire drill record for the fire drill conducted on 4/14/24 at 1:15 AM does not include the amount of time it took for evacuation or the number of staff persons participating. These sections of the fire drill record are blank.

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Unannounced fire drill held on 6/17/24 by Maintenance Director, all documentation completed per regulation. Administrator educated on regulation 132c fire drill records on 7/17/24 by direct supervisor. All staff that conduct fire drills will be re-educated on regulation 132c by 7/30/24 by direct supervisor. Documentation of the education will be kept in accordance with 2600.65i. Administrator or designee will perform audits monthly to ensure documentation completed per regulation. (DIRECTED: The administrator monthly audits shall begin on 8/1/24. [redacted] 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

132c - Fire Drill Records *(continued)*

Directed Completion Date: *08/13/2024*

Implemented ([redacted] - 11/18/2024)

132d - Evacuation

20. 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 has no documentation from a fire safety expert within the past year indicating a maximum evacuation time to evacuate residents to a public thoroughfare or to a fire-safe area. The evacuation time for the following fire drill exceeded 2 minutes, 30 seconds:

- *2/29/24 at 11:15 AM-Evacuation time was 4 minutes, 15 seconds*

The evacuation time is blank on the fire drill records for the following fire drills, so it is unable to be determined if residents were evacuated within 2 minutes, 30 seconds:

- *4/13/24 at 9:26 PM*
- *4/14/24 at 1:15 AM*

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Unannounced Fire Drill held in June with evacuation time listed. Fire Safety expert scheduled to come to building on 7/22/24. (DIRECTED: Documentation of the most recent fire safety inspection and supervised fire drill conducted by a fire safety expert shall be kept, which includes the maximum evacuation time to a public thoroughfare or to the fire-safe areas as designated in writing within the past year by a fire safety expert. [redacted] 7/24/24). Administrator educated on regulation 132d - Evacuation by direct supervisor on 7/17/24. All staff that conduct fire drills re-educated on regulation. Documentation of the education will be kept in accordance with 2600.65i. Administrator will perform audits monthly starting with next fire drill to ensure fire drill documents were completed accurately. (DIRECTED: The administrator monthly audits shall begin on 8/1/24 to ensure compliance with 2600.132d. [redacted] 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Not Implemented ([redacted] - 11/18/2024)

132f - Alternate Exit Routes

21. Requirements

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

132f - Alternate Exit Routes *(continued)*

Description of Violation

According to the home's fire drill records, the following fire drills were the only fire drills conducted within the past year. During the 3 fire drills that were conducted, the same exits of "2 AL exits and 1 AL exit" were used during each fire drill:

- *4/14/24 at 1:15 AM*
- *4/13/24 at 9:26 PM*
- *2/29/24 at 11:15 AM*

Plan of Correction ***Directed (- 07/25/2024)***

Unannounced Fire Drill held in June with alternate exit routes listed. Administrator educated on regulation 132f - Alternate exit routes by direct supervisor on 7/17/24. All staff that conduct fire drills re-educated on regulation. Documentation of the education will be kept in accordance with 2600.65i. Administrator will perform audits monthly to ensure alternate exit routes are utilized starting with August fire drill. (DIRECTED: The administrator monthly audits shall begin on 8/1/24 to ensure compliance with 2600.132f. 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

141a 1-10 Medical Evaluation Information

22. 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. 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 #2's medical evaluation, dated does not include an assessment of resident #2's ability to self-administer medications. This section of resident #2's medical evaluation is blank.

Plan of Correction ***Directed (- 07/25/2024)***

Resident #2 assessed by Personal Care Administrator (Registered Nurse) for self administration of medications;

141a 1-10 Medical Evaluation Information (continued)

Resident RASP updated to include inability self administer medications after consultation with physician on 7/18/24 by Administrator. Administrator will complete audit of admissions in the last 90 days to determine if self administration was assessed by 8/5/24. Random audits will continue monthly on 10 random residents to ensure continued compliance. (DIRECTED: The monthly audits shall begin on 8/1/24 and be conducted by the administrator/designee. [redacted] 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

DIRECTED: By 8/5/24: The administrator/designee shall review all current resident records to ensure each resident has a medical evaluation, completed in its entirety, at least 60 days prior to admission or within 30 days after admission. [redacted] 7/24/24

DIRECTED: By 8/5/24: The administrator shall develop and implement a new admission checklist to ensure a medical evaluation is completed in its entirety for all new admissions within 60 days prior to admission or within 30 days after admission. The completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated by the administrator on the new checklist. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 7/24/24

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Not Implemented ([redacted] - 11/18/2024)

183d - Prescription Current

23. 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 6/5/24, resident #5 Glargine-YFGN insulin was discontinued; however, was still present in the home's medication cart on 6/14/24.

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Wellness Director discarded discontinued medication for resident #5 on 6/14/24. all staff that administer medications will be educated at training scheduled for 7/30/24 on regulation 183-d Prescription current and the disposal of discontinued medications by administrator on 7/30/24 at scheduled training session. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 7/24/24.) Administrator or designee will perform audit by 8/1/24 of medication carts for disposal of discontinued medications for all residents. Administrator or designee will continue to perform random audits of medication carts for disposal of discontinued medications monthly of 8 random residents. (DIRECTED: The monthly audits shall begin on 8/1/24. [redacted] 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

183d - Prescription Current *(continued)*

Not Implemented ([redacted] - 11/18/2024)

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:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #1 is prescribed Acetaminophen 650 mg suppository-Insert 1 suppository rectally every 6 hours as needed; however, on 6/14/24, resident #1's pharmacy label indicated Acetaminophen 650 mg suppository-Insert 1 suppository rectally every 4 hours as needed.

On 6/14/24, no pharmacy label was present on resident #5's Humalog kwik pen insulin injection pen.

Plan of Correction ***Accept ([redacted] - 07/25/2024)***

Labels obtained for medications for resident #1 and resident #5 and were added to the medications by the director of wellness on 6/20/24 . All staff that administer medications will be re-educated on 184a-Resident's meds labeled at staff training scheduled for 7/30/24 by Administrator. Documentation of the staff education will be kept in accordance with 2600.65i. Administrator or wellness director will perform random audits monthly on 10 residents to verify continued compliance beginning on 8/10/24. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Not Implemented ([redacted] - 11/18/2024)

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 #1 is prescribed Hyoscyamine SL 0.125 mg tablet-Take 1 tablet by mouth every 3 hours as needed; however, on 6/14/24, this medication was not present in the home and available for administration.

On 6/14/24, resident #5's glucometer was not set to the current date and time.

On 6/14/24 at 2:12 PM, there were 2 red sharp containers labeled "Biohazard infectious Waste" present on resident #5's bedroom dresser. One container was full, and the 2nd container was approximately 1/3 full.

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Directed (- 07/25/2024)***

Resident #5's glucometer was set to the correct date and time on 7/15/24 by Wellness Director. Sharps containers were removed from resident #5's room by Wellness Director on 6/17/24. All staff that administer medications will be educated on procedures for reordering medications prior to depleting the current supply, resident glucometers shall be set to the current date and time and the safe location of storage of sharps containers by Administrator at training session scheduled for 7/30/24. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 7/24/24). Administrator or wellness director will perform audit by 8/1/24 on glucometers and sharps containers to ensure glucometers display the correct date and time and no sharps containers are present in resident's room. Administrator or Administrative Assistant will perform random audits of 5 residents monthly to verify continued compliance which will start the week of 8/10/24. (DIRECTED: The audits shall include a review of all medications for each resident to ensure all prescribed medications are present in the the home and available for administration. The audits shall also include a walkthrough of the home at least monthly to ensure sharps containers are stored in an area that is locked. 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

DIRECTED: Within 24 hours of receipt of the plan of correction: Unless discontinued in writing by the prescriber, the administrator shall ensure resident #1's Hyoscyamine SL-0.125mg tablets are present in the home and available for administration. 7/24/24

DIRECTED: Beginning on 8/1/24: The administrator/designee shall inspect all resident glucometers at least quarterly to ensure they are set to the current date and time. 7/24/24

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Not Implemented (- 11/18/2024)

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

On 6/5/24, resident #2 was prescribed Clotrimazole Betameth cream-Apply topically to soles of feet once daily. On 6/14/24, this medication was not present in the home. According to staff persons, the medication has not been delivered from the pharmacy since it was prescribed; however, this medication was initialed on resident #2's June 2024 MAR as administered by staff persons on 6/11/24, 6/13/24 and 6/14/24.

Resident #3's June 2024 MAR does not include the initials of the staff persons who administered numerous medications to resident #3 at 8:00 PM on 6/4/22, to include the following medications:

- *Menthol-Zinc Oxide Ointment-Apply topically to right buttock twice a day*
- *Quetiapine-50 mg tablet-Take 1/2 tablet (25 mg) by mouth once a day at bedtime*
- *Sertraline 100 mg tablet-Take 1 tablet by mouth at bedtime*
- *Melatonin 3 mg tablet-Take 1 tablet by mouth at bedtime*

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction ***Directed (- 07/25/2024)***

Resident #2's Clotzimazole Betameth cream was delivered by pharmacy to the home on 6/18/24. Resident #3's passed away on . Staff that administer medications to be educated at training session scheduled for 7/30/24 on regulation 1877b-Date/Time of Medication Administration. documentation of the staff education shall be kept in accordance with 2600.65i. Random audits of 10 residents MAR will be performed weekly x4 weeks then monthly by Administrator of designee on completion of medication documentation in MAR. (DIRECTED: The audits shall begin on 8/1/24. 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

187d - Follow Prescriber's Orders

27. Requirements

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

Description of Violation

On 6/5/24, resident #2 was prescribed Clotrimazole Betameth cream-Apply topically to soles of feet once daily. However, on 6/14/24, this medication was not present in the home, and according to staff persons, the medication has not been delivered from the pharmacy since it was prescribed.

Resident #2 is prescribed Humalog 100 u/ml Insulin-Inject subcutaneously with meals per sliding scale: 120-122=1 unit; 123-137=2 units; 138-152=3 units; 153-167=4 units; 168-182=5 units; 183-197=6 units; 198-212=7 units; 213-227=8 units; 228-242=9 units; 243-257=10 units; 258-272=11 units; 273-287=12 units; 288-302=13 units; 318-332=15 units; 333-347=16 units; 348-362=17 units; 363-377=18 units; 378-392=19 units; 393-407=20 units; 408-422=21 units; 423-437=22 units; 438-449=23 units; >450 call MD. According to resident #2's June 2024 MAR, on 6/8/24 at 6:00 AM resident #2's blood sugar was 221 and should have received 8 units of insulin; however, resident #2 was administered 11 units of insulin.

Plan of Correction ***Directed (- 07/25/2024)***

Resident #2's Clotzimazole Betameth cream was delivered by pharmacy to the home on 6/18/24. No ill effects to resident #2 for receiving 11 units of Humalog. All staff that administer medications to be educated at training session scheduled for 7/30/24 on administering insulin as per sliding scale parameters and medication documentation. Documentation of the staff education shall be kept in accordance with 2600.65i. Administrator wellness director e will perform random audits beginning the week of August 1st of 10 residents weekly x 4 weeks then monthly on sliding scale documentation and medication documentation/availability. (DIRECTED: The audits shall begin on 8/1/24 and include a review of all medications and medication administration records for each resident to ensure all medications are present and available in the home for administration and to ensure the directions of the prescriber are followed in accordance with 2600.187d. 7/24/24). QM meeting scheduled for

187d - Follow Prescriber's Orders (continued)

8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Not Implemented (- 11/18/2024)

224a - Preadmission Screen Form

28. Requirements

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

Description of Violation

Resident #5 was admitted to the home on however, resident #5's preadmission screening is undated, so it is unable to be determined if it was completed within 30 days prior to admission. Also, resident #5's preadmission screening does not include a determination that the home can meet the service needs of the resident. This section of resident #5's preadmission screening form is blank.

Plan of Correction ***Directed (- 07/25/2024)***

Administrator completed preadmission screen on resident #5 on 7/18/24. Administrator re-educated on regulation 224a - Preadmission Screen form by direct supervisor on 7/18/24. Admission checklist will be developed and implemented by 8/1/24 and all staff persons involved in admission process will be educated on admission checklist by implementation date of 8/1/24. Documentation of the education will be kept in accordance with 2600.65i. (DIRECTED: Copies of the completed new admission checklists shall be kept in each resident's record. 7/24/24). Administrator will perform audits on admissions within the last 90 days to ensure completion of preadmission screen by 8/1/24. Audits will be performed on all new admissions by the administrator monthly to ensure continued compliance. (DIRECTED: The monthly administrator audits shall begin on 8/1/24. 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

DIRECTED: By 8/5/24: The administrator/designee shall review all current resident records to ensure each resident has a preadmission screening, completed in its entirety, at least 30 days prior to admission. 7/24/24

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

225a - Assessment 15 Days

29. Requirements

2600.

225a - Assessment 15 Days *(continued)*

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

Description of Violation

Resident #2's medical evaluation, dated [redacted], includes diagnoses of Restless Leg Syndrome, Ulcerative Colitis, Mood Disorder, Major Depressive Disorder and Hypostatic Pneumonia; however, these diagnoses are not indicated on resident #2's assessment, dated [redacted]

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Resident #2's diagnosis were updated to include Restless Leg Syndrome, Ulcerative Colitis, Mood Disorder, Major Depressive Disorder and Hypostatic Pneumonia by Administrator on 7/18/24. Admission checklist will be developed and implemented by 8/1/24 and all staff persons involved in admission process will be educated on admission checklist by implementation date of 8/1/24. Documentation of the education will be kept in accordance with 2600.65i. (DIRECTED: Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 7/24/24). Administrator or designee with perform audit by 8/1/24 of current resident assessments and charts to verify diagnosis are documented. Administrator or designee will continue random audits monthly of 10 residents ~~x 3 months~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The monthly audits shall continue. [redacted] 7/24/24). to ensure continued compliance. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Not Implemented ([redacted] - 11/18/2024)

225c - Additional Assessment

30. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's most recent medical evaluation, dated [redacted], includes diagnoses of Insomnia, Major Depressive Disorder and Constipation; however, these diagnoses are not indicated on resident #3's most recent assessment, dated [redacted]

Resident #4's most recent medical evaluation, dated [redacted], includes diagnoses of Insomnia, Constipation, retention of urine, Hyperlipidemia, Major Depressive Disorder, Gastroesophageal Reflux Disease and Polyneuropathy; however, these diagnoses are not indicated on resident #4's most recent assessment, dated [redacted]

REPEAT VIOLATION: 9/22/2023

225c - Additional Assessment (continued)

Plan of Correction ***Accept (- 07/25/2024)***

Resident #3 passed away on . Resident #4's diagnosis we updated to include: Insomnia, Constipation, retention of urine, Hyperlipidemia, Major Depressive Disorder, Gastroesophageal Reflux Disease and Polyneuropathy on 7/18/24 by Administrator. All staff persons who are responsible for completing/updating resident assessments shall be re-educated on this regulation by 7/30/24 by Administrator or Direct supervisor. Documentation of the staff education shall be kept in accordance with 2600.65i. Administrator or designee with perform audit by 08/01/24 of all current resident assessments and charts to verify diagnosis are documented. Administrator or designee will continue random audits monthly of 10 resident charts to ensure continued compliance. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Not Implemented (- 11/18/2024)

227d - Support Plan Medical/Dental

31. 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 #4's most recent assessment, dated , indicates resident #4 requires assistance with transferring in/out of bed/chair and turning and positioning in bed/chair; however, on 6/13/24, a 1/2 length bedrail was present at the top of resident #4's bed, which is not indicated on resident #4's most recent support plan, dated

Plan of Correction ***Directed (- 07/25/2024)***

Resident #4's support plan was updated to include 1/2 side rail by administrator on 7/18/24. All staff will be educated at training on 7/30/24 on regulation 227d-support plan medical/dental and updating support plans on resident care needs change. documentation of the education will be kept in accordance with 2600.65i. Administrator or designee will perform audit of residents support plans to ensure accuracy that residents need for siderails are documented in the support plan by 8/1/2024. Administrator or Administrative Assistant will perform audits randomly on 15 residents monthly ~~x 3 months~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The monthly audits shall continue. 7/24/24). to verify continued compliance with residents needs being documented in the support plan. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

231e - No Objection Statement

32. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

There is no statement present in resident #1's record indicating resident #1 and resident #1's designated person have not objected to resident #1's admission to the home's SDCU. Resident #1 was admitted to the home's SDCU on [redacted].

There is no statement present in resident #3's record indicating resident #3 and resident #3's designated person have not objected to resident #3's admission to the home's SDCU. Resident #3 was admitted to the home's SDCU on [redacted]

Plan of Correction ***Directed ([redacted] - 07/25/2024)***

Resident #1's objective statement signed on 6/16/24 by residents designated person. (DIRECTED: By 7/30/24: The administrator shall ensure resident #1 has also signed the no objection statement. The signed acknowledgment shall be kept in resident #1's record. [redacted] 7/24/24). This was placed in residents record. Resident #3 passed away on [redacted]. Administrator re-educated on regulation 231e - objective statement by direct supervisor on 7/18/24. Admission checklist will be developed and implemented by 8/1/24 and all staff persons involved in admission process will be educated on admission checklist by implementation date of 8/1/24. (DIRECTED: Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 7/24/24). Documentation of the education will be kept in accordance with 2600.65i. Administrator will audit current resident charts of residents that reside in the SCU for completion of objective statements by 8/1/24. Random audits of 5 resident charts will be performed monthly to ensure objective statements are present in resident charts. (DIRECTED: The monthly audits shall begin on 8/1/24 and be conducted by the administrator/designee. [redacted] 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented ([redacted] - 11/18/2024)

236 - Staff Training

33. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person A, hired on [redacted], *routinely works in the home's SDCU; however, did not receive any dementia care and services training during the 2023 training year.*

Direct care staff person C, hired on [redacted], *routinely works in the home's SDCU; however, only received 4.75 hours of dementia care and services training during the 2023 training year.*

236 - Staff Training (continued)

Plan of Correction ***Directed (- 07/25/2024)***

Administrator was educated on regulation 236 staff training on 7/18/24 by direct supervisor. Staff person's A and C will be trained by the administrator on missing educations by 8/5/24. All staff members will be educated on the importance of completing annual educations on time at training scheduled for 7/30/2024. The Administrator or Administrative assistant shall review all staff training monthly to ensure all direct care staff persons who work in the SDCU receive dementia training in accordance with 2600.236 during each training year. (DIRECTED: The monthly review of staff trainings shall begin on 8/1/24 to ensure compliance with 2600.236. 7/24/24). The home's staff training plan shall also be reviewed during the monthly reviews. QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *08/13/2024*

Implemented (- 11/18/2024)

251b - Record Entries Legible

34. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was present on the signature page of resident #5's resident-home contract, dated .

Plan of Correction ***Directed (- 07/25/2024)***

Resident #5's contract signature page was amended on 7/18/24. This page replaces the signature page where correction fluid was present All staff will be educated that correction fluid is not permitted to be used by Administrator at training session scheduled for 7/30/24. Documentation of the education shall be kept in accordance with 2600.65i. Administrator will perform audit of all resident contracts by 8/1/24 to monitor for sure of correction fluid. Administrator will perform random monthly audits of 10 resident records from multiple sources x3 months to verify continued compliance beginning in September. (DIRECTED: The audits shall begin on 9/1/24. 7/24/24). QM meeting scheduled for 8/13/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 08/21/2024

Directed Completion Date: *09/01/2024*

Implemented (- 11/18/2024)

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

Facility Information

Name: *BEECHWOOD COURT AT LAFAYETTE MANOR* **License #:** *40961* **License Expiration:** *09/21/2024*

Address: *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA 15401*

County: *FAYETTE* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *LAFAYETTE MANOR INC LMI*

Address: *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA, 15401*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/27/2000* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *67* **Waking Staff:** *50*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *08/29/2024*

Inspection Dates and Department Representative

08/29/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served:** *51*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Memory Care* **Capacity:** *15* **Residents Served:** *13*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *51*

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

Have Mobility Need: *16* **Have Physical Disability:** *1*

Inspections / Reviews

08/29/2024 - Partial

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

Inspections / Reviews *(continued)*

09/11/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/25/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/18/2024*

09/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/25/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/26/2024*

11/18/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/25/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 8/18/24 at approximately 10:00 p.m. direct care staff person B and direct care staff person C witnessed direct care staff person D handle resident #1 in a rough manner during incontinence care and witnessed direct care staff person D smack resident #1's hand while stating, "I don't have time for this [redacted]." Direct care staff person E overheard direct care staff person B explain to direct care staff person A that "I almost punched direct care staff person D because [redacted] was being so rough with resident #1" and direct care staff person C indicated the way direct care staff person D handled resident #1 during incontinence care was "abusive." However, the incident of suspected abuse was not immediately reported to the Department of Aging in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 – 10225.707) and 6 Pa. Code Sections 15.21 – 15.27 (relating to reporting suspected abuse) and was not verbally reported to the Department of Aging until 8/23/24 at approximately 10:00 a.m., and in writing until 8/29/24 at approximately 12:00 p.m.

REPEAT VIOLATION 9/22/23

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

In response to the violation on 8/29/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 08/29/2024 by the Administrator to Complete Act 13 reporting forms and provide them to Adult Protective Services. To enhance the currently compliant operations, on 08/22/2024 the Administrator held an immediate education with all staff on abuse and abuse reporting. Documentation of staff education will be kept in accordance with Regulation 2600.65(i). Administrator, Administrative Assistant and wellness director was educated on regulation 15a by direct supervisor on 9/5/24. This process will be ongoing and added to the annual education for staff. QM meeting will be conducted 9/20/24 to review compliance with staff education and ongoing compliance with reporting per regulation 15a.

Licensee's Proposed Overall Completion Date: *09/21/2024*

Implemented ([redacted] - 11/18/2024)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 8/18/24 at approximately 10:00 p.m. direct care staff person B and direct care staff person C witnessed direct care staff person D handle resident #1 in a rough manner during incontinence care and witnessed direct care staff person D smack resident #1's hand while stating, "I don't have time for this [redacted]." Direct care staff person E overheard direct care staff person B explain to direct care staff person A that "I almost punched direct care staff person D because [redacted] was being so rough with resident #1" and direct care staff person C indicated the way direct care staff person D handled resident #1 during incontinence care was "abusive." However, direct care staff person D was not immediately suspended in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 – 10225.707) and

15b - Supervisor Plan (continued)

6 Pa. Code Sections 15.21 – 15.27 (relating to reporting suspected abuse) and continued to provide direct care services to resident #2 until the end of the shift at approximately 10:30 p.m. Direct care staff person D returned to work on 8/21/24 from approximately 6:00 a.m. until approximately 10:00 p.m., provided direct care services to the home's residents, and was not suspended until the morning of [redacted]

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

Administrator, Administrative Assistant and wellness director was educated on regulation 15b by direct supervisor on 9/5/24. To enhance the currently compliant operations, on 08/22/2024 the Administrator held an immediate education with staff on abuse and abuse reporting. Audit of all allegations of abuse by the administrator to ensure any staff person alleged of abuse will be immediately suspended or placed on a written plan of supervision submitted and pre-approved by the Department and the Area on Aging starting 9/17/2024. Documentation of staff education will be kept in accordance with Regulation 2600.65(i). QM meeting will be conducted 9/20/24 to review compliance with staff education and ongoing compliance with reporting per regulation 15b.

Licensee's Proposed Overall Completion Date: *09/21/2024*

Implemented ([redacted] - 11/18/2024)

15d - Resident Abuse-Notification

3. Requirements

2600.
15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

On 8/18/24 at approximately 10:00 p.m. direct care staff person B and direct care staff person C witnessed direct care staff person D handle resident #1 in a rough manner during incontinence care and witnessed direct care staff person D smack resident #1's hand while stating, "I don't have time for this [redacted]*" Direct care staff person E overheard direct care staff person B explain to direct care staff person A that "I almost punched direct care staff person D because* [redacted] *was being so rough with resident #1" and direct care staff person C indicated the way direct care staff person D handled resident #1 during incontinence care was "abusive." However, the home did not immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 – 10225.707) and 6 Pa. Code Sections 15.21 – 15.27 (relating to reporting suspected abuse) and did not notify the designated person until 8/22/24 at approximately 4:00 p.m.*

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

Resident R1's family was notified of incident when administrator was notified on 8/22/24. Administrator, Administrative assistant and wellness director educated by direct supervisor on 9/5/24 on regulation 15d. To enhance the currently compliant operations, on 08/22/2024 the Administrator held an immediate education with staff on abuse and abuse reporting. audit of all allegations of abuse by the administrator to ensure the resident and resident's designated person will immediately be notified of suspected abuse or neglect involving the resident starting 9/17/24. Documentation of staff education will be kept in accordance with Regulation 2600.65(i). QM meeting will be conducted 9/20/24 to review compliance with staff education and ongoing compliance with reporting per regulation 15d.

Licensee's Proposed Overall Completion Date: *09/21/2024*

Implemented ([redacted] - 11/18/2024)

16c - Written Incident Report

4. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 8/18/24 at approximately 10:30 p.m., direct care staff person A, the shift supervisor, was notified by direct care staff person B and direct care staff person C of an allegation of abuse involving direct care staff person D and resident #1. On 8/18/24 at approximately 10:00 p.m. direct care staff person B and direct care staff person C witnessed direct care staff person D handle resident #1 in a rough manner during incontinence care and witnessed direct care staff person D smack resident #1's hand while stating, "I don't have time for this [redacted]." Direct care staff person E overheard direct care staff person B explain to direct care staff person A that "I almost punched direct care staff person D because [redacted] was being so rough with resident #1" and direct care staff person C indicated the way direct care staff person D handled resident #1 during incontinence care was "abusive." However, the incident of suspected abuse was not reported to the Department's personal care home regional office or the Department's personal care home complaint hotline within 24 hours in a manner designated by the Department and was not reported to the Department until 8/23/24 at 9:47 a.m.

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

Incident reported by administrator on 8/23/24 to the department. Administrator, Administrative assistant and wellness director educated by direct supervisor on 9/5/24 on regulation 16c. To enhance the currently compliant operations, on 08/22/2024 the Administrator held an immediate education with all staff on abuse and abuse reporting. Audit of all allegations of abuse by the administrator to ensure compliance with Regulation 2600.16(c) starting 9/17/2024. Documentation of staff education will be kept in accordance with Regulation 2600.65(i). QM meeting will be conducted 9/20/24 to review compliance with staff education and ongoing compliance with reporting per regulation 16c.

Licensee's Proposed Overall Completion Date: *09/21/2024*

Implemented ([redacted] - 11/18/2024)

42b - Abuse

5. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 8/18/24 at approximately 10:00 p.m. direct care staff person B and direct care staff person C witnessed direct care staff person D handle resident #1 in a rough manner during incontinence care and witnessed direct care staff person D smack resident #1's hand while stating, "I don't have time for this [redacted] Direct care staff person E overheard direct care staff person B explain to direct care staff person A that "I almost punched direct care staff person D because [redacted] was being so rough with resident #1" and direct care staff person C indicated the way direct care staff person D handled resident #1 during incontinence care was "abusive."

Plan of Correction ***Accept ([redacted] - 09/18/2024)***

Administrator, Administrative assistant and wellness director educated by direct supervisor on 9/5/24 on regulation 42b. Staff person D was terminated. To enhance the currently compliant operations, on 08/22/2024 the Administrator held an immediate education with all staff on abuse and abuse reporting. Private interviews will

42b - Abuse (continued)

begin on 9/18/24 of 3 residents weekly x 3 months then monthly by the Administrator or Administrative Assistant. documentation of staff education will be kept in accordance with Regulation 2600.65(i). QM meeting will be conducted 9/20/24 to review compliance with staff education and ongoing compliance with reporting per regulation 42b.

Licensee's Proposed Overall Completion Date: *09/21/2024*

Implemented (- 11/18/2024)

141b2 - Medical Evaluation Changes

6. Requirements

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #3's status change medical evaluation, dated , was missing the medical professional's license number for the physician, physician's assistant or certified registered nurse practitioner who completed the evaluation, that area of the form was left blank.

Plan of Correction ***Accept (- 09/11/2024)***

Administrator, Administrative Assistant and Wellness Director were educated on regulation 141b2 by direct supervisor on 9/5/2024 Resident R3's status change medical evaluation was completed by medical professional on 8/30/2024. Administrator or Administrative Assistant will perform audit on resident medical evaluations in the past 3 months to verify completion by 9/13/24. Administrator or administrative assistant will perform audits weekly x4 weeks then monthly x3 months starting on 9/16/2024 to ensure continued compliance. QM meeting will be conducted 9/20/24 to review compliance with staff education and ongoing compliance with reporting per regulation 141b2.

Licensee's Proposed Overall Completion Date: *09/25/2024*

Implemented (- 11/18/2024)

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

Facility Information

Name: *BEECHWOOD COURT AT LAFAYETTE MANOR* **License #:** *40961* **License Expiration:** *09/21/2024*

Address: *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA 15401*

County: *FAYETTE* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *LAFAYETTE MANOR INC LMI*

Address: *145 LAFAYETTE MANOR ROAD, UNIONTOWN, PA, 15401*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/27/2000* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *67* **Waking Staff:** *50*

Inspection Information

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

Reason: *Complaint, Interim* **Exit Conference Date:** *10/03/2024*

Inspection Dates and Department Representative

10/01/2024 - On-Site: [redacted]

10/03/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served:** *46*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st floor* **Capacity:** *23* **Residents Served:** *14*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *46*

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

Have Mobility Need: *21* **Have Physical Disability:** *2*

Inspections / Reviews

10/01/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/02/2024*

11/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/01/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/08/2024*

11/07/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/07/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/15/2024*

12/02/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/15/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

29a SOPb1- Hospice Care: Doctor Certification

1. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

1. A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

Description of Violation

Resident #1, who was on hospice, was not evacuated during the following fire drills; however, no documentation from a physician was present indicating resident #1 was actively dying and may suffer bodily injury or a hastened death as a result of participation in the fire drills:

- *9/10/24 at 9:45 AM*
- *8/22/24 at 6:15 AM*
- *7/22/24 at 11:05 AM*

Plan of Correction ***Directed (- 11/07/2024)***

Resident #1 CTB on . All staff persons shall be re-educated on regulation 29a SOPb1 and all hospice statement policies at training session scheduled for 11/14/2024 by Administrator. Documentation of the education shall be kept in accordance with 2600.65i. Administrator will audit monthly fire drills to ensure all residents are evacuated or have proper physician certification monthly starting with October fire drill 4. Regulations will be reviewed during the fire drill each month starting with November fire drill. (DIRECTED: During the monthly administrator fire drill record audits, the administrator shall ensure all statement of policy Hospice care and services regulations specified in 2600.29a(SOP) through 2600.29b11(SOP) are followed for all residents who are actively dying and not evacuated during fire drills, 11/7/24). QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 11/25/2024

Directed Completion Date: *11/15/2024*

Not Implemented (- 12/02/2024)

65a - FS Orientation 1st Day

2. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

65a - FS Orientation 1st Day *(continued)*

Description of Violation

Direct care staff person A was hired on [redacted]; however, did not receive orientation on any of the topics specified in 2600.65a until [redacted]

REPEAT VIOLATION: 6/29/2022, et. al.

Plan of Correction ***Directed ([redacted] - 11/07/2024)***

Direct Care staff person A was provided orientation on subjects listed in 65a on [redacted]. Documentation of staff person A's orientation will be kept in accordance with 2600.65i. Copies of all completed new hire checklists shall be kept in each staff person's record. Staff person A's untimely education root cause was caused by oversight of previous administrator. All educations will be kept in accordance with 2600.65i. Administrator or HR Director will perform audits on new hire employee personnel files monthly starting 11/8/2024 to ensure orientation topics in 65a are completed. The Human Resource Director shall review all current staff person records to ensure each staff person has received orientation on all topics specified in 2600.65a by 11/8/2024. Administrator or Human resources will review each new hire checklist on start date to ensure all educations are completed timely per regulation. (DIRECTED: The administrator or Human Resource audits shall begin on 11/12/24. [redacted] 11/7/24). QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 11/25/2024

Directed Completion Date: *11/15/2024*

Not Implemented ([redacted] - 12/02/2024)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff person A was hired on [redacted]; however, did not receive orientation on the following topics:

- *Emergency medical plan*
- *Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act*
- *Reporting of reportable incidents and conditions*

REPEAT VIOLATION: 6/29/2022, et. al.

Plan of Correction ***Directed ([redacted] - 11/07/2024)***

Staff person A was educated on required topics by Administrator on [redacted] Staff person A's orientation will be kept in accordance with 2600.65i. Copies of all completed new hire checklists shall be kept in each staff person's record.Staff person A's untimely education root cause was caused by oversight of previous administrator. Administrator or HR Director will perform audits on new hire employee personnel files monthly starting 11/8/24 to

65b - Rights/Abuse 40 Hours (continued)

ensure orientation topics in 65a are completed. The Human Resource Director shall review all current staff person records to ensure each staff person has received orientation on all topics specified in 2600.65b by 11/8/2024. Administrator or Human resources will review each new hire checklist on start date to ensure all educations are completed timely per regulation. (DIRECTED: The administrator or Human Resource audits shall begin on 11/12/24. [redacted] 11/7/24). QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Proposed Overall Completion Date: 11/25/2024

Directed Completion Date: *11/15/2024*

Not Implemented ([redacted] - 12/02/2024)

101j7 - Lighting/Operable Lamp

4. Requirements

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

Description of Violation

On 10/1/24, no operable lamp or other source of lighting that can be turned on/off at bedside was present next to resident #2's bed.

Plan of Correction ***Accept ([redacted] - 11/04/2024)***

Administrator replaced lamps in resident #2s room. Administrator performed audit of all residents rooms to ensure a lamp is present by 11/1/2024. All staff persons shall be re-educated on regulation 101j7 at training session scheduled for 11/14/2024 by Administrator. Documentation of the education shall be kept in accordance with 2600.65i. Administrator or Administrative assistant will continue audit for lamps being present in all resident rooms weekly x 4 weeks then monthly. QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented ([redacted] - 12/02/2024)

132h - Designated Meeting Place

5. 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

According to the home's fire drill records, resident #1 was not evacuated to a designated meeting place or to a fire-safe area during the following fire drills:

- *9/10/24 at 9:45 AM*
- *8/22/24 at 6:15 AM*
- *7/22/24 at 11:05 AM*

Plan of Correction ***Accept ([redacted] - 11/04/2024)***

Resident #1 CTB on [redacted] All staff persons shall be re-educated on regulation 132h at training session

132h - Designated Meeting Place (continued)

scheduled for 11/14/2024 by Administrator. Documentation of the education shall be kept in accordance with 2600.65i. Administrator will audit monthly fire drills to ensure all residents are evacuated or have proper physician certification monthly starting with the October Fire Drill. QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented ([redacted] - 12/02/2024)

141a - Medical Evaluation

6. 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

No medical evaluation was completed for resident #4, who was admitted to the home on [redacted]

Plan of Correction ***Accept ([redacted] - 11/07/2024)***

Resident #4s Medical evaluation was completed on 10/3/2024. Administrator or Administrative assistant will complete audit of all resident charts to determine if medical evaluation was completed by 11/8/2024. Administrator or Administrative assistant will continue audits monthly with each new admission to ensure continued compliance with medical evaluation. Admissions checklist implemented 10/28/2024 and in use. All staff persons involved in the admission process shall be educated by the administrator on the new admission checklist by 11/14/2024. Documentation of the education shall be kept in accordance with 2600.65i. . QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.ttached.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented ([redacted] - 12/02/2024)

141a 1-10 Medical Evaluation Information

7. 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. 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.

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

Description of Violation

Resident #3's medical evaluation, dated [redacted] does not include a list of resident #3's medications. The medication addendum section of resident #3's medical evaluation is blank.

REPEAT VIOLATION: 6/29/2022, et. al.

Plan of Correction ***Accept ([redacted] - 11/07/2024)***

Resident #3s medical evaluation was completed on 10/2/2024. Administrator or Administrative assistant will complete audit of all resident charts to determine if medical evaluation was completed entirely by 11/8/2024.Administrator or Administrative assistant will continue audits monthly with each new admission to ensure continued compliance with medical evaluation.. Admissions checklist implemented 10/28/2024 and in use. All staff persons involved in the admission process shall be educated by the administrator on the new admission checklist by 11/14/2024. Documentation of the education shall be kept in accordance with 2600.65i. . QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented ([redacted] - 12/02/2024)

183d - Prescription Current

8. 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 10/3/24, resident #5's Nystatin 100,000 unit/gram powder was present in the home; however, this medication was discontinued on 8/8/24.

Plan of Correction ***Accept ([redacted] - 11/07/2024)***

Wellness Director discarded discontinued medication for resident #5 medication immediately. All staff that administer medications will be educated at training scheduled for 11/14/24 on regulation 183-d Prescription current and the disposal of discontinued medications by administrator on 11/14/24 at scheduled training session. Documentation of the staff education shall be kept in accordance with 2600.65i. Administrator or designee will perform audit by 11/8/24 of medication carts for disposal of discontinued medications for all residents. Administrator or designee will continue to perform random audits of medication carts for disposal of discontinued medications weekly x4 weeks of 10 random residents then monthly of 15 random residents. QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented ([redacted] - 12/02/2024)

183e - Storing Medications

9. Requirements

2600.

183e - Storing Medications *(continued)*

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 10/3/24, resident #6's Lantus Solostar insulin pen was open and undated. According to the manufacturer's instructions, Lantus Solostar insulin pens must be discarded within 28 days of opening.

REPEAT VIOLATION: 4/7/2023

Plan of Correction ***Accept (- 11/07/2024)***

Resident #6s lantus was discarded by wellness director immediately and replaced with new pen that was dated when opened. All staff that administer medications will be educated at training scheduled for 11/14/24 on regulation 183-e storing medications by administrator on 11/14/24 at scheduled training session. Documentation of the staff education shall be kept in accordance with 2600.65i. Administrator or designee will perform audit by 11/8/24 of medication carts for proper dating of insulin pens. Administrator or designee will continue to perform random audits of medication carts to include 5 residents for proper dating/storing of medications weekly x4 weeks and then monthly x3 months. QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Implemented (- 12/02/2024)

184a - Resident's Meds Labeled

10. Requirements

2600.

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

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

On 8/5/24, resident #6 was prescribed Lantus Solostar 100 u/ml-Inject 40 units subcutaneously twice daily; however, resident #6's pharmacy label indicates Lantus Solostar-Inject 30 units subcutaneously daily.

Resident #7 is prescribed Humalog 100 u/ml-Inject subcutaneously with meals in accordance with the following sliding scale: 120-122=1 unit; 123-137=2 units; 138-152=3 units; 153-167=4 units; 168-182=5 units; 183-197=6 units; 198-212=7 units; 213-227=8 units; 228-242=9 units; 243-257=10 units; 258-272=11 units; 273-287=12 units; 288-302=13 units; 303- 317=14 units; 318-332=15 units; 333-347=16 units; 348-362=17 units; 363-377=18 units; 378-392=19 units; 393-407=20 units; 408-422=21 units; 423-437=22 units; 438-449=23 units; 450-1,000 call MD; however, the pharmacy label for resident #7's Humalog does not include the sliding scale orders after blood sugar readings of 197.

Plan of Correction ***Directed (- 11/07/2024)***

Label obtained for resident #6s Lantus and were added to the medication by the Wellness Director immediately. All staff that administer medications will be educated at training scheduled for 11/14/24 on regulation 184a resident meds labeled by administrator on 11/14/24 at scheduled training session. Documentation of the staff education

184a - Resident's Meds Labeled (continued)

shall be kept in accordance with 2600.65i. Administrator or designee will perform audit by 11/8/24 of medication carts for proper labeling of insulin pens. Administrator or designee will continue to perform random audits of medication carts proper labeling of insulin pens weekly x4 weeks and then monthly x3 months. QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

DIRECTED: By 11/10/24: The administrator shall ensure an accurate and complete pharmacy label, which includes the sliding scale coverage, is present on resident #7's Humalog insulin. [redacted] 11/7/24

Proposed Overall Completion Date: 11/25/2024

Directed Completion Date: *11/15/2024*

Not Implemented ([redacted] - 12/02/2024)

185a - Implement Storage Procedures

11. 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 #6 is prescribed Humalog 100 u/ml-Inject subcutaneously before meals in accordance with sliding scale. On 10/2/24 at approximately 4:00 PM, resident #6's blood sugar was 266; however, was documented as 261 on resident #6's October 2024 medication administration record (MAR).

REPEAT VIOLATION: 6/29/2022, et. al.

Plan of Correction ***Accept ([redacted] - 11/04/2024)***

Physician was notified of resident #6s missed dose of Humalog and inaccurate documentation of blood glucose – medication error form completed. All staff that administer medications will be educated at training scheduled for 11/14/24 on regulation 185a implement storage procedures. Documentation of the staff education shall be kept in accordance with 2600.65i. Administrator or designee will perform audit by 11/8/24 of diabetic residents blood glucose for the last 10 days and compare to the MAR for proper documentation and insulin given per order. Administrator or designee will continue to perform random audits of 4 residents weekly x4 weeks and then monthly x3 months. QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented ([redacted] - 12/02/2024)

225a - Assessment 15 Days

13. Requirements

2600.

225a - Assessment 15 Days *(continued)*

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

Description of Violation

Resident #8's medical evaluation, dated [redacted] includes diagnoses of insomnia and hypothyroidism; however, these diagnoses are not included on resident #8's assessment, dated [redacted]

Plan of Correction ***Accept ([redacted] - 11/07/2024)***

Resident #8's diagnosis were updated to include diagnosis of insomnia and hypothyroidism on 10/3/2024 by Administrative Assistant. Admission checklist was implemented 10/28/2024 and all staff persons involved in admission process will be educated on admission checklist by 11/14/2024 and that the admission checklist must be kept in each residents record. Administrator or designee with perform audit by 11/8/2024 of current resident assessments and charts to verify diagnosis are documented. Administrator or designee will continue random audits monthly of 10 residents weekly x4 weeks and then monthly to ensure continued compliance. QM meeting scheduled for 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented ([redacted] - 12/02/2024)

225c - Additional Assessment

14. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #9's most recent medical evaluation, dated [redacted] includes diagnoses of allergies, insomnia, and depression; however, these diagnoses are not included on resident #9's most recent assessment, dated [redacted].

Resident #10's most recent medical evaluation, dated [redacted], includes diagnoses of insomnia, constipation, retention of urine, hyperlipidemia, major depressive disorder, gastroesophageal reflux disease and unspecified polyneuropathy; however, these diagnoses are not included on resident #10's most recent assessment, dated [redacted].

REPEAT VIOLATION: 9/22/2023

Plan of Correction ***Accept ([redacted] - 11/04/2024)***

Resident #9s and Resident #10s diagnosis were updated on 10/2/2024 by administrative assistant. All staff persons who are responsible for completing/updating resident assessments shall be re-educated on this regulation by 11/14/24 by Administrator or Direct supervisor. Documentation of the staff education shall be kept in accordance with 2600.65i. Administrator or designee with perform audit by 11/8/24 of all current resident assessments and charts to verify diagnosis are documented. Administrator or designee will continue random audits monthly of 10

225c - Additional Assessment (continued)

resident charts to ensure continued compliance. QM meeting scheduled 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Not Implemented (- 12/02/2024)

231b - Medical Evaluation

15. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the home's secured dementia care unit (SDCU) on [redacted] however, resident #3's medical evaluation was not completed until [redacted]. Also, resident #3's medical evaluation does not include the need for resident #3 to be served in the home's SDCU.

Plan of Correction ***Accept (- 11/07/2024)***

Resident #3s medical evaluation was updated by the provider on 10/2/2024 to include residents need to be served in SDCU. Admission checklist was implemented 10/28/2024 and all staff persons involved in admission process will be educated on admission checklist by 11/14/2024 and that the admission checklist must be kept in each residents record. All staff persons who are responsible for completing/updating resident medical evaluations shall be re-educated on this regulation by 11/14/24 by Administrator or Direct supervisor. Documentation of the staff education shall be kept in accordance with 2600.65i. Administrator or designee with perform audit by 11/8/24 of all current resident medical evaluations and charts of residents in the memory care unit to verify completion and documentation of residents need to be served in the homes SDCU. Administrator or designee will continue random audits monthly of 10 resident charts to ensure continued compliance. QM meeting scheduled 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Implemented (- 12/02/2024)

231c - Preadmission Screening

16. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the home's SDCU on [redacted]; however, resident #3's cognitive preadmission screening is dated as completed on [redacted].

Resident #4 was admitted to the home's SDCU on [redacted] however, resident #4's cognitive preadmission screening is dated as completed on [redacted]

231c - Preadmission Screening (continued)

Plan of Correction ***Accept ([redacted] - 11/07/2024)***

All staff involved in admission process for residents in SDCU will be educated on regulation 231c and Admission checklist by direct supervisor by 11/1/2024 . Documentation of the staff education shall be kept in accordance with 2600.65i. . Administrator or designee with perform audit by 11/8/24 of all current resident of residents in the memory care pre admission cognitive screen to verify completion of cognitive pre screen within 72 hours. Administrator or designee will perform audit monthly of all new admissions to SDCU to verify that cognitive preadmission screening within 72 hours of admission is completed Starting 11/11/2024. This regulation is included on the new admission checklist. QM meeting scheduled 11/15/2024 which will include a review of all items specified in 2600.26b and documentation of the QM review will be kept.

Licensee's Proposed Overall Completion Date: *11/25/2024*

Implemented ([redacted] - 12/02/2024)