pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **PREMIER OAKWOOD TERRACE OPERATING LLC**
LEGAL ENTITY

To operate **OAKWOOD TERRACE**
NAME OF FACILITY OR AGENCY

Located at **400 GLEASON DRIVE, MOOSIC, PA 18507**
(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 **58**
(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 13**

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 **November 20, 2024** until **November 20, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226610**

ISSUING OFFICER

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 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: November 20, 2024

[redacted]
Premier Oakwood Terrace Operating, LLC
400 Gleason Drive
Moosic, Pennsylvania 18507

RE: Oakwood Terrace
License#:226610

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on September 4, 2024 and September 5, 2024, and the corrections you have made after our inspection we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

November 15, 2024

[redacted]
PREMIER OAKWOOD TERRACE OPERATING LLC
[redacted]

RE: OAKWOOD TERRACE
400 GLEASON DRIVE
MOOSIC, PA, 18507
LICENSE/COC#: 22661

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/04/2024, 09/05/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *OAKWOOD TERRACE* **License #**: *22661* **License Expiration**: *10/23/2024*

Address: *400 GLEASON DRIVE, MOOSIC, PA 18507*

County: *LACKAWANNA* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *PREMIER OAKWOOD TERRACE OPERATING LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/02/1998* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *46* **Waking Staff**: *35*

Inspection Information

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

Reason: *Complaint, Provisional, Incident* **Exit Conference Date**: *09/05/2024*

Inspection Dates and Department Representative

09/04/2024 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served**: *35*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Pine* **Capacity**: *35* **Residents Served**: *5*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *35*

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

Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

09/04/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/06/2024*

Inspections / Reviews *(continued)*

10/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/10/2024*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

11/13/2024 - Bypass Document Submission

Submitted [redacted] **Date Submitted:** *10/10/2024*

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 9/5/2024, at 9:30am, Department Representative observed a binder with medication administration records left on top of medication cart #2. The MedTech was not at the cart.

Repeat Violation 2/16/24

Plan of Correction ***Accept [redacted] - 10/08/2024)***

1. On 9/5/24 Surveyor requested a med pass audit be done using a paper MAR. Med Tech #1 was not familiar with using paper MAR because we usually use electronic MAR. Immediate action was taken by administration to notify med techs to always close MAR when it is unattended. This was also corrected at the time of inspection. Immediate action was taken, and MAR was removed and moved to secured health room at the time of inspection.

2. We revised our policies and procedures on record confidentiality regarding using paper and electronic MAR's and ensuring that they are closed or turned off when administrating medication. This revision is included.

3. On 9/30/24 the executive director individually coached med Tech #1 regarding [redacted] record confidentiality error and the use of a paper MAR. Additionally, an all Med Tech inservice was held on 9/30/24 to re-educate all med techs on the importance of record confidentiality. These trainings are included.

4. The Executive Director or designee Wellness Director will be responsible for monitoring the continued compliance of record confidentiality.

5. The Executive Director or designee Wellness Director will complete weekly audits for 3 months or until 100% compliance is achieved using our 2600.17 audit tool. The results will be discussed at our monthly QA meetings to ensure compliance. This audit tool is included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented ([redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

18 - Compliance With Laws

2. Requirements

2600.

18 - Compliance With Laws *(continued)*

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

Description of Violation

The Homes carbon monoxide detector located in the Pine section was not dated with an installation date. The Pennsylvania care facility carbon monoxide alarm standard act indicated that carbon monoxide detector batteries are to be changed and dated annually.

Plan of Correction ***Accept [redacted] - 10/08/2024)***

1. On 9/5/24 the carbon monoxide detector batteries were changed and dated immediately during inspection.

2. Checking carbon monoxide detector batteries and dates was added to our newly implemented maintenance director's environmental compliance rounds tool. This tool is included.

3. On 9/30/24 our maintenance director was individually coached on the importance of dating and checking carbon monoxide detectors batteries monthly to ensure compliance with laws. This training is included.

4. The executive director or designee maintenance director will be responsible for monitoring the continued compliance of carbon monoxide detectors in the home.
5. A newly implemented environmental compliance rounds tool will be completed weekly by maintenance director. The executive director or designee maintence director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.18 audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

25b - Contract Signatures

3. Requirements

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

Description of Violation

The following resident contracts were not signed by the residents:

Resident #1 contract dated [redacted]24
Resident #2 contract dated [redacted]24
Resident #3 contract dated [redacted]/24
Resident #4 contract dated [redacted]/24

25b - Contract Signatures *(continued)*

Plan of Correction ***Accept[redacted] - 10/08/2024)***

1. Resident's #1, #2, #3, and #4's contracts were immediately updated on 9/5/24 to include resident signatures or unable to sign due to current diagnosis section.

2. Contract was revised to indicate that resident, responsible party, and oakwood terrace representative signature is needed to complete contract. An additional line was added also to the contract to identify if a resident is unable to sign their contract due to current diagnosis. A 100% audit was conducted on 9/30/24 to ensure that all contracts were updated to include resident signatures or unable to sign due to current diagnosis section. This audit is included.

3. On 9/30/24 the executive director and marketing director were trained on the importance of ensuring all contracts are signed by residents if capable. This training is included.

4. The executive director or the designee marketing director will be responsible for monitoring the continued compliance of contract signatures.

5. The executive director or the designee marketing director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.25b audit tool. The results will be discussed at our monthly QA meeting to ensure compliance is achieved. This audit tool is included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented[redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

65b - Rights/Abuse 40 Hours

4. 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.
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A (Date of Hire [redacted]/2024) completed their 40th scheduled work hour on 8/8/2024. However, this staff person did not complete training in the following topics: Emergency Medical Plan and reportable incidents.

Repeat Violation: 2/16/24

Plan of Correction ***Accept[redacted] - 10/09/2024)***

1. The emergency medical plan was signed by staff person A on 8/5/24. The policy and procedures on reportable incidents was signed by staff person A on 7/31/24. Both trainings were within first 40hours of work time period.

65b - Rights/Abuse 40 Hours (continued)

The trainings were not printed and in staff person A's employee file at the the time of survey. On 9/5/24 both trainings were immediately printed and included in staff person A's employee file.

2. To ensure continued compliance of 2600.65b we have implemented a direct care orientation plan final check addendum. This includes that the human resources director and executive director need to sign and review that the direct care orientation plan is completed 100% and within the first 40 hours of working. Additionaly a 100% audit was completed on 9/30/24 reviewing all employee files and ensuring all training is 100% complete. This audit and addendum is included.

3. On 9/30/24 the human resources director was individually coached on the importance of ensuring all employee trainings are completed within first 40 hours worked. This includes emergency medical plan and the policy and procedures on reportable incidents. This training is included.

4. The executive director or designee Human Resources director will be responsible for monitoring the continued compliance of 2600.65b rights/abuse 40 hours.

5. The executive director or designee Human Resources director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.65b audit tool. The results will be discussed at our monthly QA meeting to ensure compliance is achieved. This audit tool is included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

65d - Initial Direct Care Training

[redacted]

91 - Telephone Numbers

6. Requirements

2600.

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

Description of Violation

On 9/4/2024, the phone in Willow House did not have the required emergency numbers posted at or near the phone.

91 - Telephone Numbers *(continued)*

Plan of Correction ***Accept ([redacted] - 10/09/2024)***

1. On 9/5/24 emergency phone numbers were immediately posted above willow house telephone. To ensure these emergency phone numbers are not taken down, our maintenance director framed them and bolted them to the wall. A picture of this is included.

2. Checking if emergency phone numbers are posted near all phone in facility was added to our newly implemented maintenance director's weekly environmental compliance rounds tool. This tool is included.

3. On 9/30/24 our maintenance director was individually coached on the importance of checking if emergency phone numbers are posted by all facility phones this ensures complete compliance with 2600.91. This training is included.

4. The executive director or designee maintenance director will be responsible for monitoring the continued compliance of maintaining emergency telephone numbers by all telephones used in facility.

5. A newly implemented environmental compliance rounds tool will be completed weekly by maintenance director. The executive director or designee maintence director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.91 audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented ([redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

103e - Left Overs

7. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 9/4/2024, the kitchen refrigerator had the following unlabeled and undated items in it: a bag of ham, and a bag of sliced cheese. The kitchen freezer had a bag of lobster shells that was undated and unlabeled.

Plan of Correction ***Accept [redacted] - 10/09/2024)***

1. On 9/5/24 the ham, sliced cheese, and lobster shells were all labeled and dated immediately.

2. A newly implemented sticker system indicating open date and expiration date was applied to all goods in kitchen refrigerator and freezer. This is color coded with bright colors to aid in the visualization of proper open dates. A 100% audit was conducted on 9/30/24 by designee dietary supervisor to ensure complete compliance of 103e. This sticker system and 100% audit is included.

3. The dietary director was individually coached on the importance of making sure all goods in kitchen refrigerator and freezer are being labeled and dated properly. This training also included education on our newly implemented

103e - Left Overs (continued)

color coded sticker labels.

4. The executive director or designee dietary director will be responsible for monitoring the continued compliance of ensuring all kitchen refrigerator and freezer goods are dated and labeled correctly.

5. We have implemented a new color-coded sticker system to ensure all goods are labeled and dated properly. The executive director or designee dietary director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.103e audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. This audit tool and sticker system is included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

103f - Refrigerator/Freezer Temps

8. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 9/4/2024, the refrigerators located in the Oak section and Willow section did not have a thermometer to determine their temperatures.

Plan of Correction ***Accept ([redacted] - 10/09/2024)***

1. On 9/5/24 a thermometer was immediately added and zip tied to Oak and Willow hallway refrigerators. Pictures of both refrigerators with thermometers is included.

2. Checking if thermometers are in all facility refrigerators was added to our newly implemented maintenance director's environmental compliance rounds tool. This tool is included.

3. On 9/30/24 our maintenance director was individually coached on the importance of ensuring all facility refrigerators have a thermometer included to ensure complete compliance of 103f. This training is included.

4. The executive director or designee maintenance director will be responsible for monitoring the continued compliance of maintaining thermometers in all facility refrigerators.

5. A newly implemented environmental compliance rounds tool will be completed weekly by maintenance director. The executive director or designee maintenance director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.103f audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

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

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

141a - Medical Evaluation

9. Requirements

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

Description of Violation

Resident #3 was admitted to the home on [redacted]/2024. The Documentation of Medical Evaluation (DME) form was not completed until 7/17/2024.

Plan of Correction ***Accept [redacted] - 10/09/2024)***

1. During weekly DME audits due to past compliance we self identified that resident #3's DME was not signed by MD. We immediately corrected this on 7/17/24 and had DME completed prior to survey. This was not completed in a timely manner but was found during our weekly QA audits.

2. Moving forward we have newly implemented a 100% completion sign off addendum to be included with our completed DME's. This includes wellness director and executive directors signature to ensure 100% completion of DME's. We have also included DME completion tracking in a timely manor to our weekly risk management tool. Both the addendum and tool are included. Also, a 100% audit of all current resident DME's was conducted on 9/30/24 to ensure complete compliance. This 100% audit is included.

3. On 9/30/24 our wellness director was individually coached on the importance of ensuring all resident DME's are completed 100% in allowed time period to ensure complete compliance of 141a. This training is included.

4. The executive director or designee wellness director will be responsible for monitoring the continued compliance of ensuring all resident DME's are completed 100% and in allowed time period.

5. A newly implemented 100% completion sign off addendum has been added to our DME's to ensure complete compliance. Also, we have updated our weekly risk management tool to include DME compliance. Both the addendum and weekly risk management tool is included. Additionally, The executive director or designee wellness director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.141a audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. This audit tool is included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

141a 1-10 Medical Evaluation Information

10. Requirements

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

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 #1's DME dated [redacted]/2024 was missing the height and pulse rate.

Plan of Correction ***Accept ([redacted] - 10/09/2024)***

1. On 9/5/24 resident #1's DME was updated to include missing height and pulse rate immediately. DME was faxed to MD and returned signed.

2. Moving forward we have newly implemented a 100% completion sign off addendum to be included with our completed DME's. This includes wellness director and executive directors signature to ensure 100% completion of DME's. We have also included DME completion tracking in a timely manor to our weekly risk management tool. Both the addendum and tool are included. Also, a 100% audit of all current resident DME's was conducted on 9/30/24 to ensure complete compliance. This 100% audit is included.

3. On 9/30/24 our wellness director was individually coached on the importance of ensuring all resident DME's are completed 100% in allowed time period to ensure complete compliance of 141a 1-10. This training is included.

4. The executive director or designee wellness director will be responsible for monitoring the continued compliance of ensuring all resident DME's are completed 100% and in allowed time period.

5. A newly implemented 100% completion sign off addendum has been added to our DME's to ensure complete compliance. Also, we have updated our weekly risk management tool to include DME compliance. Both the addendum and weekly risk management tool is included. Additionally, The executive director or designee wellness director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.141a 1-10 audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. This audit tool is included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

171b5 - First Aid Kit

11. Requirements

171b5 - First Aid Kit *(continued)*

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 9/4/2024, the first aid kit stored in the home's vehicle did not contain a thermometer.

Plan of Correction ***Accept [redacted] - 10/09/2024)***

1. On 9/5/24 a thermometer was immediately added to the company vehicle's first aid kit. A picture is included.

2. Checking if a thermometer is included in our facility car's first aid kit was added to our newly implemented maintenance director's environmental compliance rounds tool. This tool is included.

3. On 9/30/24 our maintenance director was individually coached on the importance of ensuring our company car has a thermometer include in its first aid kit, this ensures complete compliance of 103f. This training is included.

4. The executive director or designee maintenance director will be responsible for monitoring the continued compliance of maintaining a thermometer in facility's vehicle first aid kit.

5. A newly implemented environmental compliance rounds tool will be completed weekly by maintenance director. The executive director or designee maintenance director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.171b5 audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

184a - Resident's Meds Labeled

12. Requirements

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

Description of Violation

Resident #1 Medication administration record stated that they are administered Nystatin cream twice daily as needed for rash. However, the pharmacy label incorrectly stated to be applied twice daily for rash.

Repeat Violation 2/16/2024

Plan of Correction ***Accept [redacted] - 10/09/2024)***

1. On 9/5/24 Resident #1's Nystatin cream was labeled immediately to match the medication administration record.

184a - Resident's Meds Labeled (continued)

2. A newly implemented 3 way cart audit tool was developed and will be used weekly to ensure continued compliance happens. This audit tool includes comparing the medications orders to the MAR, comparing the medications labels for accuracy and residents name, and ensuring the medication is available in facility. This audit tool is included. Additionaly, on 9/30/24 our wellness director completed a 100% audit on all medication labels to ensure they match the residents MAR.

3. On 9/30/24 the designee wellness director was individually coached on the importance of medication labels matching MAR. Additionally we had an all med tech training to include the importance of matching medication labels to mar, this will ensure complete compliance with 2600.184a. These trainings are included.

4. The executive director or designee wellness director will be responsible for monitoring the continued compliance of ensuring all resident's medication labels match our MAR's.

5. A newly implemented 3 way cart audit tool will be done weekly by designee wellness director. This tool is included. The executive director or designee wellness director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.184a audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

184b - Labeling OTC/CAM

13. Requirements

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

Description of Violation

On 9/4/2024, in medication cart #1 the following over the counter medications did not have a name on the bottle: fiber gummies and calcium. In medication cart #2 the following medications did not have a name on the bottle: Centrium 50+ gummies.

Plan of Correction ***Accepti[redacted] - 10/09/2024)***

1. On 9/5/24 the following medication in cart #1: Fiber gummies and calcium were immediately labeled with resident's name. The following medication in cart #2: Centrium 50+ gummies were immediately labeled with resident's name.

2. A newly implemented 3 way cart audit tool was developed and will be used weekly to ensure continued compliance happens. This audit tool includes comparing the medications orders to the MAR, comparing the medications labels for accuracy and residents name, and ensuring the medication is available in facility. This audit tool is included. Additionaly, on 9/30/24 our wellness director completed a 100% audit on all medication being labeled with appropriate resident's names. These audit tools are included.

3. On 9/30/24 the designee wellness director was individually coached on the importance of labeling all OTC

184b - Labeling OTC/CAM (continued)

medication with resident's name's. Additionally, we had an all med tech training to include the importance of labeling all OTC medication with resident's name's, this will ensure complete compliance with 2600.184b. These trainings are included.

4. The executive director or designee wellness director will be responsible for monitoring the continued compliance of labeling all OTC medication with resident's appropriate name.

5. A newly implemented 3 way cart audit tool will be done weekly by designee wellness director. This tool is included. The executive director or designee wellness director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.184b audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

185a - Implement Storage Procedures

14. 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 Fluticasone spray as needed. However, these medications were not available in the home at the time of inspection on 9/4/2024.

Plan of Correction ***Accept [redacted] - 10/09/2024)***

1. On 9/5/24 Resident #6's fluticasone spray was immediately discontinued due to nonuse.

2. A newly implemented 3-way cart audit tool was developed and will be used weekly to ensure continued compliance happens. This audit tool includes comparing the medications orders to the MAR, comparing the medications labels for accuracy and residents name, and ensuring the medication is available in facility. This audit tool is included. Additionally, on 9/30/24 our wellness director completed a 100% audit on all current PRN medications that they are in house and readily available. These audit tools are included.

3. On 9/30/24 the designee wellness director was individually coached on the importance of ensuring all PRN medication is readily available in house for residents. Additionally, we had an all med tech training to include the importance of ensuring all PRN medication is readily available in house for residents., this will ensure complete compliance with 2600.184b. These trainings are included.

4. The executive director or designee wellness director will be responsible for monitoring the continued compliance of ensuring all resident's PRN medication is readily available in house.

5. A newly implemented 3 way cart audit tool will be done weekly by designee wellness director. This tool is

185a - Implement Storage Procedures (continued)

included. The executive director or designee wellness director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.185a audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted]/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

191 - Resident Right to Refuse

15. Requirements

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

Description of Violation

The records for resident #2 and #4 did not document that the resident was educated on their right to refuse and/or question medications.

Plan of Correction ***Accept [redacted] - 10/09/2024)***

1. On 9/5/24 resident #2 and #4 were immediately educated on their right to refuse and/or question medications. Proof of education supplied.

2. Our current resident contract agreement's resident rights portion was updated to include an addendum regarding information on the right to refuse and/or question medications. Additionaly, a 100% audit was completed to ensure all current residents have this addendum added to their residents rights form. This audit is included.

3. On 9/30/24 The executive director and designee admission director was trained on the importance of ensuring all residents have the right to refuse and/or question medications. These trainings are included.

4. The executive director and the designee admissions director will be responsible for the continued compliance of ensuring all current and future residents will be educated on their right to refuse and/or question medications.

5. Our newly added addendum to resident rights which includes education on the right to refuse and/or question medication will be attached to all current and future contracts. The executive director or designee admissions director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.191 audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.

227d - Support Plan Medical/Dental

16. 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

The home's fire drill documentation indicates that resident 2 requires verbal cuing in order to evacuate the home safely during an emergency. Resident 2's assessment and support plan dated 8/12/2024 indicates the resident has no mobility issues and does not indicate that the verbal cueing is needed.

Repeat Violation 2/16/2024

Plan of Correction ***Accept (- 10/09/2024)***

1. On 9/5/24 Resident #2's RASP was updated with an addendum to include newly updated mobility needs. This was done immediately after the survey was completed.

2. We have added resident mobility need updates to our newly implemented risk management tool that is completed weekly by our designee wellness director. Additionally, a 100% audit was completed to ensure that all current residents mobility needs are up to date and match their RASP's. This audit is included.

3. On 9/30/24 the designee wellness director was individually coached on the importance of ensuring all current and future residents mobility needs are updated in their RASP as needed. This training is included.

4. The executive director and the designee admissions director will be responsible for the continued compliance of ensuring all current and future residents mobility needs are updated as needed in their RASP.

5. Our newly implemented risk management tool including mobility needs updates will be completed weekly by wellness director. The executive director or designee wellness director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.227d audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented 11/13/2024)***

Update: *11/13/2024*

Verified with on-site LIS from 10/23/2024.

233c - Key-Locking Devices

17. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

233c - Key-Locking Devices *(continued)*

Description of Violation

The gate located in the secured dementia unit's courtyard did not have instructions how to operate the electronic lock on the gate.

Plan of Correction ***Accept [redacted] - 10/09/2024)***

1. On 9/5/24 the gate located in the secured dementia unit's courtyard had instructions immediately applied to it indicating how to operate the electronic lock on the gate. Picture of instructions included.

2. Checking if both electronic locks have instructions how to operate them was added to our newly implemented maintenance director's environmental compliance rounds tool. This tool is included.

3. On 9/30/24 our maintenance director was individually coached on the importance of ensuring that the electronic locked gate always has instruction how to operate it posted next to it, this ensures complete compliance of 233c. This training is included.

4. The executive director or designee maintenance director will be responsible for monitoring the continued compliance of ensuring electronic lock gates have instructions posted next it on how to operate it.

5. A newly implemented environmental compliance rounds tool will be completed weekly by maintenance director. The executive director or designee maintenance director will be responsible for completing weekly audits for 3 months or until 100% compliance is achieved using our 2600.233c audit tool. The results will be discussed at our monthly QA meetings to ensure compliance is achieved. These audit tools are included.

Licensee's Proposed Overall Completion Date: *10/05/2024*

Bypass Document Submission ***Implemented [redacted] - 10/30/2024)***

Update: *10/30/2024*

Verified as implemented while on-site, 10/23/2024.