

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

December 4, 2024

[REDACTED], ADMINISTRATOR
UPMC SENIOR COMMUNITIES
319 WELLNESS WAY
WASHINGTON, PA, 15301

RE: STRABANE WOODS OF
WASHINGTON
319 WELLNESS WAY
WASHINGTON, PA, 15301
LICENSE/COC#: 44542

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/29/2024, 10/30/2024 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: STRABANE WOODS OF WASHINGTON **License #:** 44542 **License Expiration:** 01/28/2025
Address: 319 WELLNESS WAY, WASHINGTON, PA 15301
County: WASHINGTON **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: UPMC SENIOR COMMUNITIES
Address: 319 WELLNESS WAY, WASHINGTON, PA, 15301
Phone: [REDACTED] [REDACTED] [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 11/17/1999 **Issued By:** South Strabane Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 103 **Waking Staff:** 77

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint **Exit Conference Date:** 10/30/2024

Inspection Dates and Department Representative

10/29/2024 - On-Site: [REDACTED]
10/30/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 100 **Residents Served:** 79

Special Care Unit

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

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 79
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 24 **Have Physical Disability:** 1

Inspections / Reviews

10/29/2024 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/14/2024

11/18/2024 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 12/03/2024
Reviewer: [REDACTED] **Follow-Up Type:** Document Submission **Follow-Up Date:** 11/25/2024

Inspections / Reviews *(continued)*

12/04/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/03/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

18 Other laws, regs, ordins.

1. Requirements

2800.

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

Description of Violation

In accordance with the Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/2016, "An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance." However, on 10/29/24 at 11:20 a.m. there was no carbon monoxide detector located in or near the dry storage room of the residence's kitchen which contained a gas-operated AO Smith hot water tank.

In accordance with the Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/2016, "An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance." However, on 10/29/24 at 11:21 a.m. there was no carbon monoxide detector located in the residence's main laundry room or near the two OptiDry UniMac industrial gas-operated clothes dryers.

Plan of Correction

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

2800.18 CO detector

- 1. The maintenance person purchased two carbon monoxide detectors on 10/30/24 from Lowe's. One was mounted on the wall in close proximity to, but not less than 15 ft. of the main laundry and one was mounted on the wall inside of the dry storage room in close proximity to, but not less than 15 ft. of the hot water tank.
- 2. All other fossil-fuel burning devices or appliances were checked and determined to have a carbon monoxide detector installed in close proximity to, but not less than 15 feet from any fossil fuel-burning device or appliance on 10/29/2024.
- 3. The administrator educated the maintenance employee regarding the need to ensure that a carbon monoxide detector is installed in close proximity to, but not less than 15 feet from the fossil fuel burning device or appliance. Documentation for completion of training will be kept in accordance with 2800.65 (l). Education was completed on 11/19/2024.
- 4. The administrator or designee will complete a monthly audit for three months to verify placement of a carbon monoxide detector remains in close proximity but not less than 15 feet from the fossil-fuel device or appliance beginning within 3 business days of the receipt of an approved plan of correction.
- 5. The audit findings will be reviewed by the Administrator or designee monthly, beginning within 3 business days upon receipt of acceptance of this POC. The audit will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

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

54a Direct care staff quals

2. Requirements

2800.

54.a. Direct care staff persons shall have the following qualifications:

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

54a Direct care staff quals (continued)

Description of Violation

Direct Care Staff person A, hired [REDACTED], did not have a high school diploma, GED, or active registration status on the Pennsylvania nurse aide registry.

Plan of Correction

Accept [REDACTED] - 11/18/2024)

2800.54a HS Diploma GED

1. Direct Care employee "A" did not have a copy of [REDACTED] high school diploma in [REDACTED] employee chart. [REDACTED] did have proof that [REDACTED] attended and graduated from [REDACTED], but this was not accepted by DHS during the 10/29-10/30/24 survey. Employee "A" was asked to obtain a copy of [REDACTED] diploma and submit it to the Administrator.
2. The Administrator shall complete a retrospective review of all hires in 2024 to ensure a copy of the employee High School Diploma, GED, or an active registry status on the PA Nurse Aide registry.
3. The Regional Director will educate the Administrator all new Direct Care persons shall have a High School Diploma, GED, or an active registry status on the PA Nurse aide registry. Documentation for completion of training will be kept in accordance with 2800.65 (l). Education will be completed by 11/19/2024.
4. The Administrator will review all new hires monthly for 3 months beginning within 3 days of the receipt of an approved plan of correction.
5. Audit findings will be reviewed by the administrator or the designee monthly, beginning within 3 business days upon the acceptance of this POC and will continue for 3 months or until compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [REDACTED] - 12/04/2024)

65j Annual training content

3. Requirements

2800.

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

Description of Violation

Direct care staff person A and direct care staff person B were not trained during the 2023 training year in fire safety by a fire safety expert or by a staff person trained by a fire safety expert.

Plan of Correction

Accept [REDACTED] - 11/18/2024)

2800.65.j. Annual Fire Safety Training

1. Staff member "A" & "B" have been scheduled for training by a fire safety expert on 12/11/24.
2. Annual building specific fire safety training for all staff has been scheduled for 1/11/25. A video of the fire safety training will be made and will be utilized to meet the need of annual fire safety training by a fire safety expert or by a staff person trained by a fire safety expert. All employees will be offered Fire Safety Training for calendar year 2024.
3. The Regional Director will educate the facility Administrator that direct care staff, ancillary staff, substitute personnel and regularly schedule volunteers shall be trained annually in fire safety by a fire safety expert or by a staff person trained by a fire safety expert. Documentation for completion of the training will be kept in accordance with 2800.65 (l). Education was completed on 11/19/2024.
4. The Administrator and/or designee will audit all employee 2024 annual training transcripts through December 31, 2024, to ensure annual Fire Safety training has been offered and completed by employees as indicated. Audits will

65j Annual training content (continued)

begin within 3 business days of the receipt of an approved plan of correction.

5. Audit findings will be reviewed by the administrator or the designee monthly, within 3 business days upon the acceptance of this POC and will continue for 3 months or until compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [redacted] - 12/04/2024)

101j7 Lighting/operable lamp

4. Requirements

2800.

101.j. Each resident shall have the following in the living unit:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 10/30/24 at approximately 11:40 a.m. there was no operable source of light at bedside for resident #1 in resident living unit #215, the lamp was on a table across the room.

Plan of Correction

Accept [redacted] - 11/18/2024)

2800.101 lamp

- 1. A lamp was placed on a bedside table on 10/30/24 per reg. 2800.101 j. by the second-floor housekeeper.
- 2. All resident apartments were checked and determined to be in compliance with having a light source near their bed.
- 3. Administrator and /or designee educated all housekeepers regarding the need for a lamp at the bedside related to nighttime safety, and that if any resident is requesting for their lamp to be moved to let administration know of the resident wishes. The resident verbalized understanding. Documentation for completion of training will be kept in accordance with 2800.65 (l). Education will be completed by 11/26/2024.
- 4. The administrator or designee will audit 5 resident apartments weekly for 2 months to ensure that a lamp is at the bedside for nighttime safety. Audits will begin within 3 business days of the receipt of an approved plan of correction.
- 5. Audit findings will be reviewed by the Administrator or designee monthly beginning within 3 business days upon receipt of the acceptance of this POC. Audits will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [redacted] - 12/04/2024)

105g Dryer lint removal

5. Requirements

2800.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 10/29/24 at approximately 12:52 p.m. both General Electric gas-operated dryers in the second-floor resident laundry room had lint screens that were fully matted with lint. The left dryer's lint screen was matted across the entire surface with approximately one-eighth of an inch thick white lint, and the right dryer's lint screen was matted across the entire surface with approximately one-eighth of an inch thick blue and purple lint.

105g Dryer lint removal (continued)

REPEAT VIOLATION 2/15/23 et. al.

Plan of Correction

Accept [redacted] - 11/18/2024)

2800.105.g

1. The lint in the resident dryer was removed by the second housekeeper. Signage to "remove lint after dryer use" remains posted above each dryer.
2. At the time of the finding all dryers were checked for lint and none was found.
3. The Administrator and/or designee will education all nursing assistants and housekeepers on the need to check the dryers for lint after the use and remove as indicated. Documentation of the education will be maintained in accordance with reg. 2800.65L. A resident meeting was held on 11/11/2024 and all residents in attendance were reminded of the importance and need to remove lint from the dryers after use as indicated. Education will be completed by 11/26/2024.
4. The administrator or designee will randomly check resident dryers weekly for 2 months to ensure dryer lint is removed after use as indicated. Audits will begin within 3 business days of the receipt of an approved plan of correction.
5. Audit findings will be reviewed by the administrator or the designee monthly, within 3 business days upon the acceptance of this POC and will continue for 3 months or until compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [redacted] - 12/04/2024)

132b Safety inspection/fire drill

6. Requirements

2800.

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 residence did not have documentation of a supervised fire drill conducted by a fire safety expert for calendar years 2023 and 2024.

Plan of Correction

Accept [redacted] - 11/18/2024)

2800.132.b Fire Safety Inspection (Supervised Drill)

1. A supervised drill conducted by a fire safety expert was completed on 11/13/2024.
2. A supervised drill conducted by a fire safety expert will be scheduled for 2025. Will implement Fire Drill logs to ensure a supervised drill is scheduled and completed as indicated.
3. The Regional Director will educate the facility Administrator that a supervised fire drill by a fire safety expert is completed annually. Documentation for completion of the training will be kept in accordance with 2800.65.l. Education will be completed by 11/19/2024.
4. The Administrator and/or designee will audit fire drill logs to ensure that a supervised fire drill by a fire safety expert has been completed annually was completed as indicated. Audits will begin within 3 business days of the receipt of an approved plan of correction.
5. Audit findings will be reviewed by the administrator or the designee monthly, within 3 business days upon the acceptance of this POC and will continue for 3 months or until compliance is achieved.

132b Safety inspection/fire drill (continued)

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [REDACTED] - 12/04/2024)

132e Fire drill - sleeping hours

7. Requirements

2800.

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

Description of Violation

On 6/26/24 at 10:20 p.m. the residence conducted a sleeping hours fire drill; however, the previous sleeping hours fire drill was held on 10/31/23 at 6:00 a.m.

Plan of Correction

Accept [REDACTED] - 11/18/2024)

2800.132.e Fire Drill during Sleeping Hours

1. A fire drill during sleeping hours was completed on 11/14/2024 6:30am. At the time of the finding the Administrator verbally educated the maintenance person.
2. The 6-month Fire Drills during sleeping hours are being scheduled in advance by the Administrator and/or designee to ensure they are conducted every 6 months as required.
3. The Administrator and/or designee educated the maintenance person on the need to schedule and conduct a fire drill during the sleeping hours every 6 months. Documentation of the education will be maintained per reg. 2800.65.l. Education will be completed by 11/19/2024.
4. The Administrator and/or designee will complete a monthly audit of the fire drills to ensure a fire drill during the sleeping hours is scheduled and completed every 6 months. Audits will begin within 3 business days of the receipt of an approved plan of correction.
5. Audit findings will be reviewed by the Administrator or designee monthly, beginning within 3 business days upon receipt of the acceptance of this POC, will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [REDACTED] - 12/04/2024)

184a Resident meds labeled

8. Requirements

2800.

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

4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for resident #1's [REDACTED] tablet indicated "Take 1 tablet by mouth every day as needed." However, resident #1 is prescribed [REDACTED] tablet, take one tablet by mouth at bedtime.

The pharmacy label for resident #2's [REDACTED] tablet indicated "Take 1 tablet by mouth three times daily as needed." However, resident #2 is prescribed [REDACTED] tablet, take one tablet by mouth daily at bedtime.

The pharmacy label for resident #3's [REDACTED] did not include the instructions for administration.

184a Resident meds labeled (continued)

Resident #3 is prescribed [REDACTED], inject ten units twice daily (with breakfast and dinner).

REPEAT VIOLATION 2/15/23 et. al.

Plan of Correction

Accept [REDACTED] - 11/18/2024)

2800.184 (a) Labels

1. Upon notification of the violation "Direction Change" labels were applied immediately to the [REDACTED] and the [REDACTED] and a label was created for the [REDACTED] pen injector that included the instructions for administration.
2. All medication carts were checked to ensure that medication labels were applied and that the labels contained the required information.
3. The Director of Resident Care educated the LPN's and Medication Technicians that the prescribed dosage and instructions for administration must be included on the medication labels and to apply a "Direction Change" label as it pertains to the order changes as indicated. Documentation for completion of training will be kept in accordance with 2800.65(l). Education will be completed by 11/26/2024.
4. The DRC and/or designee will conduct weekly medication cart audits to ensure "Direction Change" labels were applied as indicated, and that [REDACTED] injectors have instructions for administration as indicated. Audits will begin within 3 business days of the receipt of an approved plan of correction.
5. The audit findings will be reviewed by the Administrator or designee monthly, beginning within 3 business days upon receipt of acceptance of this POC. The audit will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [REDACTED] - 12/04/2024)

185a Storage procedures

9. Requirements

2800.

185.a. The residence 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 #4 uses a [REDACTED] continuous glucose monitor to record blood glucose readings before meals, three times daily. However, on multiple dates and times, resident #4's October 2024 medication administration record (MAR) did not align with readings on the [REDACTED] glucometer as follows:

DATE	TIME/MAR	TIME/GLUCOMETER	MAR READING	GLUCOMETER READING
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

185a Storage procedures (continued)

[Redacted]

On [Redacted] at approximately [Redacted], resident #5's [Redacted] medication administration record documented a blood glucose reading of [Redacted]. However, resident #5's [Redacted] indicated a blood glucose reading of [Redacted].

Plan of Correction

Accept [Redacted] - 11/18/2024)

2800.185.a.

1. The [Redacted] is a Continuous Glucose Monitoring Device. The Director of Resident Care spoke with a representative from Abbott, the manufacturer for the Freestyle Libre 3, regarding the violation for resident #4 and if possible, how to manually record the reading at the ordered times.
2. As new glucometer devices are implemented staff will review processes as indicated to ensure glucometer readings used for med administration align with the MAR notation.
3. The Nurses and Medication Technicians will be educated by the Director of Resident care on the process to add a note to the glucometer reading used for the medication administration and aligning with the MAR notation. Documentation for completion of the training will be kept in accordance with 2800.65 (l). Education will be completed by 11/26/2024.
4. The Director of Resident Care and /or designee will complete a weekly audit resident using a Libre 3 Continuous Glucometer Monitoring Devices to ensure there is a note to indicate the glucometer reading that was used for the medication administration and that the reading aligns with the MAR Notation. Audits will begin within 3 business days of the receipt of an approved plan of correction.
5. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented [Redacted] 12/04/2024)

187b Date/time of med admin

10. Requirements

2800.

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

Description of Violation

Resident #1 was prescribed [Redacted], take 2 tablets by mouth daily for five days, then one tablet by mouth once daily for 30 days. However, on [Redacted] direct care staff person C, administered the 2 tablets of [Redacted] to resident #1 and did not sign the [Redacted] medication administration record at the time of administration and documented a "/" instead with no exception entered.

Plan of Correction

Accept [Redacted] - 11/18/2024)

2800.187.b subsection (a)(13) and (14) Med admin time

1. The staff care person with which the medication error occurred, was educated by the Director of Resident Care on proper documentation after administration of medications, in particular date/time of administration and name

187b Date/time of med admin (continued)

and initials of staff person administering medication.

2. The Director of Resident Care will conduct a retrospective review of the last 2 months of MARs to identify if there are any other trends associated with medication administration documentation that should be completed at the time of administration as indicated.

3. The Director of Resident Care and/or designee will educate all nurses and medication techs on the need to ensure medication administration is being documented at the time of administration as indicated. Documentation for completion of the training will be kept in accordance with 2800.65 (l). Education will be completed by 11/26/2024.

4. The Director of Resident Care and/or designee will complete audit 15 MARS per week for one month to ensure medication administration is being documented at the time of administration as indicated. Audits will begin within 3 business days of the receipt of an approved plan of correction.

5. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented (- 12/04/2024)

224a5 Written initial assessment

11. Requirements

2800.

224.a.5. The written initial assessment must, at a minimum include the following:

- iv. The individual's medical history, medical conditions, and current medical status and how they impact or interact with the individual's service needs.

Description of Violation

Resident #4's initial assessment, dated , did not include numerous medical conditions indicated on the resident's medical evaluation, dated to include:

Resident #6's initial assessment, dated , did not include numerous medical conditions indicated on the resident's medical evaluation, dated to include:

Plan of Correction

Accept - 11/18/2024)

2800.224.a.5. Initial Assessment Missing Medical Conditions

1. The initial assessment for resident #4 was revised on by the DRC to include medical conditions of . The initial assessment for resident # 6 was revised on to include medical conditions of .

2. The Director of Resident Care and/or designee will audit all previously completed initial assessments to ensure medical conditions are include as indicated.

3. The Director of Resident Care educated the Resident Support Coordinator on the need to include medical conditions on the initial assessment. Documentation for completion of training will be kept in accordance with 2800.65 (l). Education will be completed by 11/19/2024.

4. The Director of Resident Care will complete a monthly audit of any new initial assessments to ensure medical conditions are noted as indicated. Audits will begin within 3 business days of the receipt of an approved plan of correction.

5. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance

224a5 Written initial assessment (continued)

is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

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

225b Assessment content

12. Requirements

2800.

225.b. The assessment must, at a minimum include the following:

- 4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.

Description of Violation

Resident #2's annual assessment, dated [redacted], did not include numerous medical conditions indicated on the resident's medical evaluation, dated [redacted] to include: [redacted].

Resident #3's annual assessment, dated [redacted], did not include the medical condition [redacted] as indicated on the medication list attached to the resident's medical evaluation dated [redacted].

Resident #5's annual assessment, dated [redacted] and updated [redacted] and again on [redacted] did not include numerous medical conditions indicated on the resident's medical evaluation, dated [redacted] to include: [redacted].

Resident #7's annual assessment, dated [redacted] and updated [redacted] and again on [redacted], did not include numerous medical conditions indicated on the resident's medical evaluation, dated [redacted] to include: [redacted].

Plan of Correction

Accept [redacted] - 11/18/2024)

2800.225.b Missing Medical Conditions on Annual Assessment

- 1. The annual assessment for resident #2 was revised on 10/31/2024 by the Director of Resident Care to include the medical conditions of [redacted]. The annual assessment for resident # 3 was revised on [redacted] to include the medical condition of [redacted]. The annual assessment for resident # 5 was revised on [redacted] to include the medical conditions of [redacted]. The annual assessment for resident # 7 was revised to include the medical conditions of [redacted] and [redacted].

2.The Director of Resident Care and/or designee will audit all annual assessments to ensure medical conditions are include as indicated. At each quarterly review, the support plan will be reviewed by the Director of Resident Care and/or designee to verify that medical conditions are noted as indicated.

3. The Director of Resident Care educated the Resident Support Coordinator on the need to include medical conditions on the annual assessment. Documentation for completion of the training will be kept in accordance with 2800.65 (l). Education will be completed by 11/19/2024.

4. The Director of Resident Care and /or designee will complete a monthly audit of 7 annual assessments to ensure medical conditions are noted as indicated. Audits will begin within 3 business days of the receipt of an approved plan of correction.

225b Assessment content (continued)

5. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented () - 12/04/2024)

227a Final support plan – 30 days

13. Requirements

2800.

227.a. Each resident requiring services shall have a written final support plan developed and implemented within 30 days after admission to the residence. The final support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #6's final support plan, dated [redacted] indicated the resident was assessed with [redacted] and indicated "Staff will administer medications per physician orders, the staff will report any refusals of medications. Staff will monitor and report changes in health to the physician" and did not include a plan to meet the resident's assessed need of Congenital Deafness. Additionally, resident #6's final support plan did not include a description of the bed shaker and a fire alarm device used to turn on resident #6's bedside light for emergency evacuation.

Plan of Correction

Accept () - 11/18/2024)

2800.227.a. Support Plan

1. The support plan for resident # 6 was revised to include a plan to meet the resident's assessed need of [redacted] [redacted] Updates to the support plan also included adaptive emergency evacuation devices that alert the resident, due an assessed need of deafness. Additional updates included a description of the bed shaker that will cause vibration to the bed and triggers flashing of lights when the fire alarm sounds, and a doorbell that triggers lights to flash throughout the resident's apartment upon entering of the apartment.
2. The Director of Resident Care and/or designee will review all support plans for the assessed need of deafness and ensure any devices to aid in alerting a resident in the event of an emergency situation are added to the support plan as indicated. At each quarterly review, the support plan will be reviewed by the Director of Resident Care and/or designee to verify that assistive devices are noted as indicated.
3. The Resident Support Coordinator was educated by the Director of Resident Care regarding the need to review all support plans for the assessed need of deafness and ensure any devices to aid in alerting a resident in the event of an emergency are added to the support plan as indicated. Documentation for completion of this training will be kept in accordance with 2800.65 (l). Education will be completed by 11/19/2024.
4. The Director of Resident Care and /or designee will complete a monthly audit of 7 support plans to ensure adaptive emergency equipment is noted in the support plan as indicated. Audits will begin within 3 business days of the receipt of an approved plan of correction.
5. Audit findings will be reviewed by the Administrator and/ or designee monthly, beginning within 3 business days upon receipt of the acceptance of this plan of correction, will continue for 3 months or until substantial compliance is achieved.

Licensee's Proposed Overall Completion Date: 11/14/2024

Implemented () - 12/04/2024)