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

January 23, 2025

[REDACTED], EXECUTIVE
MDT ALF 1, LLC
[REDACTED]

RE: LEGEND AT SILVER CREEK
425 LAMBS GAP ROAD
MECHANICSBURG, PA, 17050
LICENSE/COC#: 33925

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/19/2024, 11/20/2024 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: *LEGEND AT SILVER CREEK* **License #**: *33925* **License Expiration**: *10/04/2025*

Address: *425 LAMBS GAP ROAD, MECHANICSBURG, PA 17050*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MDT ALF 1, LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *07/14/2023* **Issued By**: *Hampden Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *121* **Waking Staff**: *91*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Renewal, Complaint* **Exit Conference Date**: *11/20/2024*

Inspection Dates and Department Representative

11/19/2024 - On-Site:

11/20/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *108* **Residents Served**: *97*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *24* **Residents Served**: *20*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *97*

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

Have Mobility Need: *24* **Have Physical Disability**: *0*

Inspections / Reviews

11/19/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/13/2024*

Inspections / Reviews *(continued)*

12/17/2024 - POC Submission

Submitted By: [redacted]

Date Submitted: *01/20/2025*

Reviewer: [redacted]

Follow-Up Type: *POC Submission* **Follow-Up Date:** *12/24/2024*

12/26/2024 - POC Submission

Submitted By: [redacted]

Date Submitted: *01/20/2025*

Reviewer: [redacted]

Follow-Up Type: *Document Submission* **Follow-Up Date:** *01/21/2025*

01/23/2025 - Document Submission

Submitted By: [redacted]

Date Submitted: *01/20/2025*

Reviewer: [redacted]

Follow-Up Type: *Not Required*

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 11/19/24, the home's current violation reports, dated 4/30/24, 5/21/24 and 7/11/24, were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 12/26/2024)***

The violation occurred because the former Administrator failed to post the licensing inspection summaries to maintain compliance with regulatory parameters.

The Regional Operations Specialist/designee shall educate the Administrator and Designee by 12/31/24 on the requirements 2600.3.c to post current inspection results. Documentation shall be kept.

On 11/20/2024, the current Administrator of the home verified and placed the LIS in a binder clearly labeled and readily available 24/7, accessible at will, and located in the building's entry lobby.

Effective 11/20/2024, the Administrator will continue to monitor the LIS's presence weekly to ensure compliance. The Administrator will monitor the LIS by physically observing and clarifying its presence weekly.

Proposed Overall Completion Date: 01/01/2025

Licensee's Proposed Overall Completion Date: *01/01/2025*

Implemented (- 01/23/2025)

63a - First Aid/CPR Training

2. 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 11/8/24, during the overnight shift, 96 residents were present in the home. During this time only 1 staff person was present in the home who was certified in First Aid and CPR.

On 11/13/24, during the overnight shift, 96 residents were present in the home. During this time only 1 staff person was present in the home who was certified in First Aid and CPR.

Plan of Correction ***Accept (- 12/26/2024)***

The violation occurred because the Customer Service Associate/RD and/or Healthcare Director failed to monitor the associate credentials for CPR/BFA certification.

The Regional Operations Specialist shall educate the Administrator, Healthcare Director, and Designee on the

63a - First Aid/CPR Training (continued)

requirements of 2600.63.a and the home's process to validate that at least one CPR/first aid certified staff member works for every 50 residents by 12/31/24. Documentation shall be kept.

On 11/21/24, the Healthcare Director compared the list to the current schedule and adjusted it to ensure the required CPR and First Aid-trained staffing levels for all shifts. A CPR/First Aid class for assigned staff was held on 12/2/24.

On 12/12/24, the CSA (Customer Service Associate) completed an audit of all associate training in CPR/BFA and determined full compliance with regulatory requirements.

Beginning 11/25/24, the Administrator, Healthcare Director, and/or designee shall review the upcoming weekly schedule and make adjustments with the Direct Care Staff Scheduler to ensure required CPR and first-trained staffing levels are present for all shifts. In addition, each month, the Administrator/designee shall review the CPR and First Aid training credentials tracker and compare it to the monthly staff schedule to ensure ongoing compliance.

Proposed Overall Completion Date: 01/01/2025

Licensee's Proposed Overall Completion Date: *01/01/2025*

Implemented (█ - 01/23/2025)

65a - FS Orientation 1st Day

3. 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.

Description of Violation

Staff person A and B, who began working for the home in 2024 , did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

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

Plan of Correction ***Accept (- 12/26/2024)***

The violation occurred because the Administrator and the Maintenance Director failed to complete and record the training required on day #1 of onboarding. Staff person B's record of this training was in another associate's office after the inspection for staff person B but was not filed in the correct location and, therefore, unavailable for the inspector's review.

Staff person A and Staff person B are no longer active associates.

The Regional Operations Specialist shall educate the Administrator and the Maintenance Director by 12/31/24 on the requirements 2600.65.a for the first day of orientation and the home's process for providing and documenting the provided education. Documentation shall be kept.

By 12/31/24, the Customer Service Associate or designee shall review the current associate onboarding training file for compliance with the regulatory requirements using the Associate Management File Checklist and the 8/40 record of training documentation form to ensure proper training is provided and recorded. Associates missing the required training shall receive the necessary training before working the next scheduled shift. Documentation shall be kept.

Effective immediately, 11/21/24, and ongoing, the Administrator, Customer Service Associate, or designee will complete a final review, before filing, of the new associate onboarding training file for compliance with the regulatory requirements using the Associate Management File Checklist and the 8/40 record of training documentation form to ensure proper training is provided and recorded. Associates missing the required training shall receive the necessary training before working the next scheduled shift.

Proposed Overall Completion Date: 01/01/2025

Licensee's Proposed Overall Completion Date: *01/01/2025*

Implemented (- 01/23/2025)

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:

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.

Description of Violation

Staff Person A and B completed 40th scheduled work hour. However, Staff Person A and B did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

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

Plan of Correction ***Accept (- 12/26/2024)***

The violation occurred due to the Administrator, the Maintenance Director, and the Healthcare Director's failure to complete and record the training required on day #1 and within the first 40 hours of onboarding. Staff person B's record of this training was in another associate's office after the inspection for staff person B but was not filed in the correct location and, therefore, unavailable for the inspector's review.

Staff person A and Staff person B are no longer active associates.

The Regional Operations Specialist shall educate the Administrator and the Healthcare Director by 12/31/24 on the requirements 2600.65.b for the first day of orientation and the home's process for providing and documenting the education provided. Documentation shall be kept.

Effective immediately, 11/21/24, and ongoing, the Administrator, Customer Service Associate, or designee will complete a final review, before filing, of the new associate onboarding training file for compliance with the regulatory requirements using the Associate Management File Checklist and the 8/40 record of training documentation form to ensure proper training is provided and recorded. Associates missing the required training shall receive the necessary training before working the next scheduled shift.

Licensee's Proposed Overall Completion Date: *01/01/2025*

Implemented (- 01/23/2025)

103d - Storing Food Off Floor

5. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 11/19/24, at 9:50 AM, two boxes of Idaho potatoes, a box of Oreo cookies and a box of Coke Cola product were stored on the floor in the dry food storage room.

Plan of Correction ***Accept (- 12/17/2024)***

The violation occurred due to the Chef and/or Cook's failure to monitor the food storage area for regulatory compliance.

Primary Benefit: *Protects food from contaminates on the floor or which may be spilled on the floor.*

The identified items were moved off the floor by the cook on 11/19/2024, at the time of the inspection.

0n 12/12/2024 The Chef/Dining Director provided re-education with all dining service staff on regulation 103d. - Food items shall not be stored on the floor.

Gold Leaf Dining training and regulatory topics are provided during the onboarding process of all new hires during the first 40 and annually as part of the training plan. In addition, effective11/21/2024 the Chef/Cook staff do inspect all food storage areas daily to ensure compliance.

103d - Storing Food Off Floor (continued)

Licensee's Proposed Overall Completion Date: *12/12/2024*

Implemented (█ - 01/23/2025)

105g - Lint Removal and Duct Cleaning

6. Requirements

2600.
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 11/19/24, there was an approximate 2-inch accumulation of lint in the lint trap of the commercial dryer. There were no clothes in the dryer at the time.

Repeated Violation - 1/3/24, et al

Plan of Correction ***Accept (█ - 12/26/2024)***

The violation occurred, although signs indicate that filters must be cleaned after each use on each dryer, because the staff failed to clean the lint out of the dryer after completing laundry.

On 11/19/24, there was an approximate 2-inch lint accumulation in the dryer filter lint trap of one of the eleven dryers in the home. The matter was resolved at the time of inspection, and the filter was cleared & cleaned. Effective 11/21/24, the Maintenance Director will continue to oversee that housekeeping staff are clearing lint filters.

Signs are present at each home's dryers, and the Direct Care staff is responsible for cleaning the lint filter/trap after each use.

The Administrator shall educate the Housekeeping and Maintenance staff on the requirements of 2600.103g by 12/31/24 to ensure an understanding of lint removal from dryer vents.

Beginning 12/13/24, the Housekeeping/Maintenance staff will check each dryer daily and clean it as needed.

Proposed Overall Completion Date: 01/01/2025

Licensee's Proposed Overall Completion Date: *01/01/2025*

Implemented (█ - 01/23/2025)

131f - Fire Extinguisher Inspection

7. Requirements

2600.

131f - Fire Extinguisher Inspection *(continued)*

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

The two fire extinguishers in the main kitchen have not been inspected by a fire safety expert since 7/2023 and 8/2023.

Plan of Correction ***Accept (- 12/26/2024)***

The violation occurred because the extinguisher company fire safety experts' bi-annual certification stamp failed, which allowed the Maintenance Director to have a new tag to continue to indicate with his initials that the monthly inspections are noted.

The extinguishers were serviced by Berkshire Monitoring Group on 12/12/24 and are fully compliant. Pictures were secured and will be uploaded in Sanswrite to verify their compliance.

On 11/26/24, the Maintenance Director and Maintenance Technician received training on regulatory requirements 2600.131f. The proper inspection tags will prevent future violations.

Beginning 12/12/24, the Maintenance Director/Fire Safety Expert will be able to continue performing monthly extinguisher checks and signing the tags accordingly.

Licensee's Proposed Overall Completion Date: *01/01/2025*

Implemented (- 01/23/2025)

183e - Storing Medications

8. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 11/20/24, 2 loose pills were found in the home's med carts and pieces of a pill were observed on the floor in the medication room.

Repeated Violation - 7/11/24 and 4/30/24, et al

Plan of Correction ***Accept (- 12/26/2024)***

The violation was incurred because the Healthcare Director/Assistant Healthcare Director/Med Tech failed to review the carts and inspect the medications to determine if they were organized and stored in a clean area, following the manufacturer's instructions. On 11/20/24, the Healthcare Director immediately discarded the two loose pills found in the home's med carts and pieces of a pill observed on the floor in the medication room.

On 11/21/24, the Healthcare Director completed an audit of medication carts and medication room, and no further findings were noted. On 11/27/24, the pharmacy provider completed an audit of medication carts, and no further findings were noted.

To prevent future violations beginning 12/6/24, the Healthcare Director/designee shall complete an audit of the medication carts weekly for 4 weeks to ensure compliance with proper medication storage. Documentation shall

183e - Storing Medications (continued)

be kept.

The Administrator shall educate the Healthcare Director/Assistant Healthcare Director and designees on the requirements 2600.183e by 12/31/24.

Licensee's Proposed Overall Completion Date: *01/01/2025*

Implemented (- 01/23/2025)

184a - Resident's Meds Labeled

9. 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's prescription for Lantus Solostar was changed on 9/2/24 by the provider from 28 units daily to 18 units daily. The pharmacy label for Resident 1's Lantus Solostar does not reflect this change.

Resident 3's prescription for Tresba FlexTouch insulin was changed on 11/8/24 by the provider from 38 units at bedtime to 20 units at bedtime. The pharmacy label for Resident 1's Tresba FlexTouch does not reflect this change.

Resident 3's prescription for Glimepiride 2mg was changed on 11/8/24 by the provider from 2 tablets at 8:00 AM to 1 tablet at 8:00 AM. The pharmacy label for Resident 3's Glimepiride does not reflect this change.

Repeated Violation - 4/30/24, et al

Plan of Correction ***Directed (- 12/26/2024)***

The violation occurred because the Healthcare Director/Assistant Healthcare Director/Med Techs failed to review the orders, and the pharmacy provider updated the medication supply/labels aligned with the MARs. On 11/20/24, the Healthcare Director immediately discarded the two loose pills found in the home's med carts and pieces of a pill observed on the floor in the medication room.

On 11/21/24, the Healthcare Director completed an audit of medication carts and medication room, and no further findings were noted.

On 11/27/24, the pharmacy provider completed an audit of medication & carts; no further findings were noted. Verification of the audit completed by the pharmacy will be uploaded into Sanswrite.

On 12/4/24, the Healthcare Director conducted an educational forum for current med tech associates. Verification of this training will be uploaded in Sanswrite accordingly.

Beginning 12/6/24, the Healthcare Director or designee shall complete an audit of the medication carts weekly for four weeks to ensure compliance. Documentation shall be kept.

184a - Resident's Meds Labeled (continued)

Proposed Overall Completion Date: 01/06/2025

[Directed]

- *The Administrator or designee will correct Resident 1 and Resident 3's pharmacy labels by 1/15/25, to ensure the prescribed dosage and instructions for administration are correct on the pharmacy label.*

Directed Completion Date: *01/15/2025*

Implemented (█ - 01/23/2025)

185a - Implement Storage Procedures

10. 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

On 11/20/24, the following discrepancies between the blood glucose reading in Resident 3's glucometer and the blood glucose reading documented in the resident's medication administration record (MAR) were observed:

- *On 11/7/24, at 4:30 PM, the documented blood glucose reading in the resident's MAR was 176. However, this blood glucose reading was not found in the resident's glucometer.*
- *On 11/8/24, at 7:30 AM, the documented blood glucose reading in the resident's MAR was 188. However, this blood glucose reading was not found in the resident's glucometer.*
- *On 11/8/24, at 11:30 AM, the documented blood glucose reading in the resident's MAR was 190. However, this blood glucose reading was not found in the resident's glucometer.*
- *On 11/12/24, at 7:30 AM, the documented blood glucose reading in the resident's MAR was 177. However, this blood glucose reading was not found in the resident's glucometer.*

Repeated Violation - 1/3/24, et al

Plan of Correction ***Accept (█ - 12/17/2024)***

With Respect to the specific deficiencies cited:
The Violation is the home did not effectively manage the calibration of the glucometer and the home failed to capture and record glucometer readings accurately.

With Respect to Systemic Measures that have been put into place to address the stated concern:
A training was completed as mandatory for all med tech staff on 12/04/2024 with the Healthcare Director/Assistant Healthcare Director and Residence Director. The purpose of the training was to review medication administration policies, procedures, interventions and resources and assistance readily available when providing medication administration.

With Respect to How the Plan of Corrective Measures will be Monitored:
The Healthcare Director/Assistant Healthcare Director commencing on 12/6/2024 will complete weekly glucometer audits to ensure the data is recorded and with accuracy. The audit information will be reviewed weekly by the

185a - Implement Storage Procedures (continued)

Healthcare Director/Assistant Healthcare Director with the Residence Director and will be inclusive in the monthly Quality Management meetings as part of the Quality Management Plan for the remainder of 2024.

Licensee's Proposed Overall Completion Date: *12/12/2024*

Implemented (- 01/23/2025)

187c - Refusal of Medication

11. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 11/2, 11/5, 11/9, 11/11, 11/14 and 11/15/24, Resident 1 refused to take the scheduled doses of several medications including Myrbetriq ER 25mg, Clopidogrel 75mg, Donepezil HCL 10mg and Atorvastatin 40mg. The home did not document the refusals in the resident's record or report the refusals to the resident's provider.

Plan of Correction ***Accept (- 12/26/2024)***

The violation was caused by Med Techs' failure to follow protocol as instructed after the Medication Administration course and upon hire.

On 11/21/24, the Healthcare Director met with Resident #1 to educate on the significance of medications and the implications of refusals. The Director also notified the physician and the Responsible Party of the identified refusals. The physician did not issue any new orders.

Immediately following the inspection on 11/20 and 11/21/24, the Healthcare Director met with each shift and re-educated all Med Techs on refusing medication policy and procedures.

Beginning 11/20/24, current medication administration technicians have been educated that if a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as the prescriber requires. Refusal forms shall be retained accordingly.

Beginning in December 2024, monthly refusals shall be reviewed at the monthly QMPI, and a plan to address trends shall be implemented.

Proposed Overall Completion Date: 01/01/2025

187c - Refusal of Medication *(continued)*

Licensee's Proposed Overall Completion Date: *01/01/2025*

Implemented (█ - 01/23/2025)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident 1 is prescribed Atorvastatin 40mg, Eliquis 5mg, Quetiapine Fumarate 25mg, Sertraline 25mg. However, on 11/14/24 at 8:00 PM, these medications were not administered to the resident.

Resident 2 is prescribed Losartan Potassium 50mg, Quetiapine Fumarate 25mg. However, on 11/14/24 at 8:00 PM, these medications were not administered to the resident.

Resident 2 is prescribed blood glucose checks twice daily. However, on 11/14/24 at 5:00 PM, the resident's blood glucose was not checked.

Resident 3 was prescribed Clotrimazole-Betamethasone cream twice a day for 14 days starting on 7/16/24. However, on 11/4/24 through 11/19/24, this medication was not administered to the resident.

Repeated Violation - 7/11/24, 4/30/24, et al and 1/3/24, et al

Plan of Correction ***Accept (█ - 12/26/2024)***

The violation was caused by Med Techs' failure to follow protocol as instructed after the Medication Administration course and upon hire. On 11/20/24, for Residents #1, #2, & #3, the resident's responsible parties and physicians were notified of missed medications, and no new orders were received from a physician.

Immediately following the inspections on 11/20 and 11/21/24, the Healthcare Director met with each shift and re-educated all Med Techs to review prescription orders, medications, and medication records to ensure the prescriber's directions are followed, including the direction of a prescribed treatment, such as the use of medical equipment or therapy.

Beginning 11/20/24, current medication administration technicians have been re-educated to ensure the prescriber's directions are followed, including the direction of a prescribed treatment, such as the use of medical equipment or therapy.

On 12/04/24, all staff who administer medication received training on the importance and procedure of following the prescriber's orders/directions.

Beginning 12/6/24, to prevent any further occurrence, the Healthcare Director and Assistant Healthcare Director

187d - Follow Prescriber's Orders (continued)

will complete weekly medication audits to verify all medications are in stock according to the physician's orders, and that all medicines are unexpired, stored safely, and available for administration/resident use. The Healthcare Director/Assistant Healthcare Director will also complete weekly glucometer audits to ensure the data is recorded accurately. The audit information will be reviewed weekly by the Healthcare Director/Assistant Healthcare Director and the Administrator. It will be included in the monthly Quality Management Team meetings as part of the Quality Management Plan for 2024.

Proposed Overall Completion Date: 01/06/2025

Licensee's Proposed Overall Completion Date: *01/06/2025*

Implemented (- 01/23/2025)

225a - Assessment 15 Days

13. Requirements

2600.
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

An assessment was not completed for Resident 2, who was admitted to the home on

Repeated Violation - 4/30/24, et al

Plan of Correction ***Accept (- 12/26/2024)***

The violation occurred because the former Assistant Healthcare Director failed to complete the document in a timely manner, print the paperwork, and add it to the chart.

Resident #2's missing assessment was discovered during a routine internal audit prior to the annual inspection. The Healthcare Director completed it on 10/31/24. The initial assessment, completed was conducted electronically but not printed and made available to the agency for review.

The home completed a full resident record audit in October 2024, before the November 2024 inspection, and all discrepancies were corrected by 10/31/2024. Therefore, the Health Care Director will review the resident records for all residents admitted after 10/31/2024 and make corrections as needed. Beginning 12/16/24, the Healthcare Director/Assistant Healthcare Director will utilize the tracker checklist to capture the document is completed, printed, and placed in the resident's chart.

The Administrator shall educate the Healthcare Director/designee by 12/31/24, on the time requirement to complete the assessment for all new admissions.

Proposed Overall Completion Date: 01/01/2025

225a - Assessment 15 Days *(continued)*

Licensee's Proposed Overall Completion Date: *01/01/2025*

Implemented (█ - 01/23/2025)

227a - Support Plan 30 Days

14. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident 2 was admitted on █ however, the resident's initial support plan was not completed.

Plan of Correction ***Accept (█ - 12/26/2024)***

The violation occurred because the former Assistant Healthcare Director failed to complete the document in a timely manner, print the paperwork, and add it to the chart.

At the time of the survey, Resident #2 did have an electronic support plan completed on 2/26/24. However, the home failed to print the document as part of the resident's paper chart. The resident also had an updated assessment completed on 10/31/24.

Beginning 12/16/24, the current Healthcare Director and Assistant Healthcare Director will complete a review of all RASPs to ensure they are compliant.

Beginning 12/16/24, the Healthcare Director or Assistant Healthcare Director will utilize the tracker checklist to ensure the document is completed, printed, and placed in the resident's chart.

By 12/31/24, the Administrator shall educate the Healthcare Director and Assistant Healthcare Director on the requirements of 2600.227.a. A written support plan must be developed and implemented within 30 days of admission, and documentation shall be kept.

227a - Support Plan 30 Days (continued)

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (█ - 01/23/2025)