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

April 30, 2025

[redacted], ADMINISTRATOR/CO OWNER
MONARCH MEADOW LLC
490 COOLSPRING STREET
UNIONTOWN, PA, 15401

RE: MONARCH MEADOW
490 COOLSPRING STREET
UNIONTOWN, PA, 15401
LICENSE/COC#: 44944

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/25/2025 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: *MONARCH MEADOW* **License #**: *44944* **License Expiration**: *08/18/2025*

Address: *490 COOLSPRING STREET, UNIONTOWN, PA 15401*

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

Administrator

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

Legal Entity

Name: *MONARCH MEADOW LLC*

Address: *490 COOLSPRING STREET, UNIONTOWN, PA, 15401*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/20/1997* **Issued By**: *Labor & Industry*

Type: *Other* **Date**: *11/30/2020* **Issued By**: *North Union Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *48* **Waking Staff**: *36*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *03/25/2025*

Inspection Dates and Department Representative

03/25/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *49* **Residents Served**: *34*

Secured Dementia Care Unit

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

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *34*

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

Have Mobility Need: *14* **Have Physical Disability**: *0*

Inspections / Reviews

03/25/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/10/2025*

04/25/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/29/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/02/2025*

Inspections / Reviews *(continued)*

04/30/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/29/2025*

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

18 - Compliance With Laws

1. Requirements

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

Description of Violation

At approximately 11:48 a.m., the Department of Health's influenza awareness poster was not posted in a public place in the home. In accordance with the Influenza Awareness Act (35 P.S. § 634.14), enacted 5/17/2016, a personal care home as defined under section 1001 of the Human Services Code shall ensure that the required influenza information is posted in a public place in the facility year-round.

Plan of Correction ***Accept (- 04/25/2025)***

On 3-25-2025, while the State inspector was at facility at approximately 1:00pm, the facility Administrator printed off the proper Influenza Awareness poster and posted in in the appropriate place at the facility. On 3-26-20025 the facility developed a new form called the Monthly Posted Documentation Review Form, this form will have all the Documentation which is to be posted at the facility according to PA regulations 2600.00. The new form will be completed monthly by facility RN, Office Manager, Supervisor, or facility Administrator. The person completing the form will round facility checking off with their initials that the proper items are posted. The person completing the form will see that any item that has been taken down, damaged, or needs fixed is properly posted and taken care of. On 4-1-2025 all staff were educated on the new form, the importance of posted documentation, and the regulatory importance of certain documentation. On 4-1-2025 the form was officially implemented, and the first review was completed by facility Administrator at the facility. A copy of the new Monthly Posted Documentation Review form and a copy of the staff education will be provided in the next step of the POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented (- 04/30/2025)

81b - Resident Personal Equipment

2. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

At approximately 11:34 a.m. there were two bedside mobility devices, one affixed to the right side of resident #1's bed, and one affixed to the right side of resident #2's bed in the shared resident room in Monarch Meadow. The device belonging to resident #1 had a series of openings that measured approximately ten-inches wide by three-inches high that were not wrapped with a protective guard and presented a risk of limb entanglement for resident #1. The device belonging to resident #2 had a series of openings that measured approximately four-inches wide and ten-inches high that were not wrapped with a protective guard and presented a risk of limb entanglement for resident #2. Additionally, the bedside mobility device belonging to resident #2 was not firmly secured to the bed frame and could be rocked back-and-forth from left to right approximately one-and-one-half inch in either direction.

Plan of Correction ***Accept (- 04/25/2025)***

On 3-25-2025 at approximately 12:30pm both bedside mobility devices were removed from the resident beds in question. On 3-26-2025, the facility Administrator and Office Manager reviewed all resident DME equipment. This

81b - Resident Personal Equipment (continued)

review was completed to ensure all DME equipment was in good working condition and was installed properly. On 3-27-2025 the facility developed a new Bedside Mobility Device Policy, the new policy states the following mandating directives regarding bedside mobility devices at facility: 1. All bedside mobility devices must have covers, regardless of openings on device or not. 2. All bedside mobility devices must be installed by DME equipment company, official DME equipment repairman, or DME Tech. 3. The new Bedside Mobility Device Questionnaire must be completed before installation of any Bedside Mobility Device at the facility. 4. The New Bedside Mobility Device Installation Checklist must be completed when the device is installed at facility.

On 3-27-2025 the facility developed a new form to assist in ensuring that a Bedside Mobility Device is appropriate for resident. The form is called the Bedside Mobility Device Questionnaire. The form will be completed before the device can be installed at facility. The following questions will need to be answered on the form: 1. What is the resident need for device? 2. What is the facility intended use for device? 3. Have the risks of the device been discussed with resident and residents designated persons? 4. Has the resident and residents designated persons agreed on the use of device? 5. Does the resident have the ability to use the device for the purpose the device is intended? 6. Has the residents RASP been updated to reflect the use of the mobility device?

On 3-27-2025 the facility also developed another form to assist that all Bedside Mobility Devices are installed according to facility expectations. The new form will be called The Bedside Mobility Device Installation Checklist, the following items will be on the checklist: 1. Date and Time of the installation of device. 2. What DME company or who is installing the device? 3. Is Bedside Mobility Device cover on the device, according to facility policy? 4. Name of supervisor who observed the installation of device

On 3-27-2025 the facility developed another form called the Bedside Mobility Device Weekly Inspection form. This form will have all the bedside mobility devices at the facility on it. The supervisor will go to each one weekly, and make sure it is secure, has a cover, and meets all the expectations of facility. On 3-29-2025 all staff were educated on the new Bedside Mobility Device Policy, the new Bedside Mobility Device Questionnaire, the new Bedside Mobility Device Installation Checklist, and the new Bedside Mobility Device Weekly Inspection. On 3-29-2025 the facility implemented all new forms, new policy, and completed the first weekly Bedside Mobility Device inspection. A copy of the new Bedside Mobility Device Policy, Bedside Mobility Device Questionnaire, Bedside Mobility Device Installation Checklist, Bedside Mobility Device Weekly Inspection Form, and a Copy of all Staff Education, will be provided in the next step of POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented ([redacted] - 04/30/2025)

92 - Windows

3. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At approximately 11:20 a.m. the window screen in resident room #3 of Monarch Meadow belonging to resident [redacted] was in a state of disrepair, the upper left corner of the screen was detached from the frame, tattered, shredded, and ripped in an area measuring approximately eight-inches wide by ten-inches high. Additionally, there were many sections throughout the entirety of the screen with small puncture holes allowing for the penetration of insects.

92 - Windows *(continued)*

Plan of Correction ***Accept ([redacted] - 04/25/2025)***

On 3-25-2025, at approximately 6:00pm the window screen in room #3 was removed and a new screen was installed into the frame of the window screen in question. On 3-26-2025 at approximately 9:00am the Administrator of facility inspected all window screens at the facility, to ensure they were all in working order, with no holes or tears. On 4-1-2025, facility ordered new screens to have on site in case a screen gets damaged. These extra screens will be stored for future use. The facility has developed a Window Screen Inspection Form to be completed monthly. This form will include the location of all the current Window Screens at the facility. A supervisor or Administrator will complete by initialing by each location, indicating it is fine. If a screen is not ok, the screen will be noted accordingly and the screen will be replaced with one from storage. On 3-29-2025, all staff were educated on the new developments regarding the window screens at the facility, the importance of window screens in good working order, and the new Form that will be completed by Supervisor or Administrator monthly. A copy of the receipt for new screens, the new Monthly Window Screen Inspection Form, and Staff education, will be provided in the next step of POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented ([redacted] - 04/30/2025)

103i - Outdated Food

4. Requirements

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

Description of Violation

At approximately 10:50 a.m., there were two bags of what appeared to be frozen biscuits in the home's 2-door Argus upright freezer that were not dated or labeled, one bag was a food handler branded Ziplock bag that contained thirteen biscuits, and the other bag was blue plastic tied shut with approximately thirty biscuits inside.

At approximately 10:57 a.m., there was a box of cucumbers in the home's Bison three-door refrigerator that had as many as five cucumbers that had what appeared to be white fuzzy dots of mold growing all over the skin of the cucumbers.

At approximately 10:57 a.m., there was an unsealed, undated bag of what appeared to be spoiled celery in the home's Bison three-door refrigerator that was water-logged, soft, a light brown color, and gave off an unusual odor that permeated the cooler.

Plan of Correction ***Accept ([redacted] - 04/25/2025)***

On 3-25-2025 at approximately 11:00am kitchen staff at facility removed all bags of biscuits in 2 door Argus Upright Freezer. The bags of biscuits were dated and labeled appropriately. On 3-25-25 at approximately 11:10am kitchen staff removed the box of cucumbers and spoiled celery from Bison Three Door Refrigerator. The items were sorted, with all spoiled items discarded appropriately. On 3-26-2025 at approximately 9:00am kitchen staff cleaned the refrigerator and freezer and appropriately inspected for all spoiled food, and confirmed all items were dated and labeled properly. On 3-27-2025 the facility developed two new forms called the Daily Refrigerator Inspection form, and the Daily Freezer Inspection form, to be placed on the refrigerator and freezer, The forms will be completed daily and staff will initial confirming the units are free of all spoiled food and that all items are dated and labeled appropriately. On 3-29-2025 all staff were educated on regulation 2600.103, the new Inspection forms, the responsibility of making sure all spoiled items are removed from refrigerator, and making sure all items are labeled

103i - Outdated Food (continued)

and Dated properly. On 3-29-2025 the new inspection forms were implemented at facility with the first entries. The New Daily Refrigerator Inspection form, the new Daily Freezer Inspection form, and Staff education will be provided in the next step of the POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented (- 04/30/2025)

121a - Unobstructed Egress

5. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At approximately 9:46 a.m. the weather strip and door sweep of the emergency exit door from the meeting room next to bedroom #8 of Swallow Tail rubbed and was caught on the wooden decking of the back ramp which prevented the emergency exit door from swinging open freely and obstructed the egress route to the back of the home's rear porch area.

REPEAT VIOLATION 6/30/23 et. al.

Plan of Correction ***Accept (- 04/25/2025)***

Due to change of weather and temperature the exit door in room # 8 of Swallowtail swells and shrinks. This causes the door to become restrictive after seasons, and door needs to be adjusted accordingly. On 3-25-2025 at approximately 11:00am the door in room #8 of Swallowtail was removed and door was adjusted accordingly. On 3-25-2025 at approximately 3:00pm the Administrator and Office Manager of the facility inspected all exits to ensure no other exit doors were stuck or not able to open appropriately. On 3-27-2025 a form that was previously developed at facility, (Weekly Egress Route/ Inspection Form), was updated with a new section to ensure all exit doors are in working order. The Weekly Egress Route/Inspection form will have a column that will ensure route is free and open, and a column that will ensure door opens freely without restriction. By staff initialing in each column, they are confirming that the Egress has been inspected and is free of debris or items, and that the door has been tested and requires no adjustment or fixing. On 3-29-2025 all staff were educated on regulation 2600.121, importance of Egress areas being open, and the POC. On 3-29-2025 the new updated Weekly Egress Route/Inspection form was implemented with the first entry. A copy of the new updated Weekly Egress Route/Inspection form, and Staff education will be provided in the next step of POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented (- 04/30/2025)

131f - Fire Extinguisher Inspection

6. Requirements

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

Description of Violation

The fire extinguisher in the Locker Room hallway and emergency exit route was tagged as last tested and inspected

131f - Fire Extinguisher Inspection (continued)

during May 2023.

Plan of Correction ***Accept (- 04/25/2025)***

The facility has a company called Advanced Fire Service who inspects all fire extinguishers at facility yearly. During the last inspection at facility, the inspector and staff accompanying failed to inspect and put a new tag on the fire extinguisher in the locker room hallway and emergency exit route of facility. On 4-3-2025 the facility Administrator notified Advanced Fire Services of the missed fire extinguisher. On 4-3-2025, the company sent a representative to tag the missed fire extinguisher and bring it up to compliance. On 3-26-2025 at approximately 9:30am the facility Administrator and Office manager rounded the facility to ensure that all fire extinguishers were properly tagged and that no more fire extinguishers were missed. On 4-3-2025 the facility developed a new form to assist fire extinguisher inspector and the staff accompanying yearly. The form will be called the Fire Extinguisher Location Form, it will contain every fire extinguisher location at facility. The Inspector and Staff accompanying will take form with them and check off the appropriate location as they inspect them. This form will also be used as a training tool for new employees and existing employees, to ensure they are aware of location all fire extinguishers in case of emergency. On 3-29-2025 all staff were educated on regulation 2600.131, the new Fire Extinguisher Location Form, the POC, and also that staff is mandated to accompany the Fire extinguisher Inspector at time of visit.
A picture of fire extinguisher with new tag on it, the new Fire extinguisher location form, and the staff education will be provided in the next step of the POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented (- 04/30/2025)

132d - Evacuation

7. Requirements

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

Description of Violation

On 3/8/24 the home conducted a fire drill with an evacuation time of 9 minutes and 48 seconds. However, the documentation of a supervised inspection by a fire safety expert dated 10/2/23 indicated the safe evacuation time for the personal care home was 9 minutes and 41 seconds.

On 4/18/24 the home conducted a fire drill with an evacuation time of 9 minutes and 51 seconds. However, the documentation of a supervised inspection by a fire safety expert dated 10/2/23 indicated the safe evacuation time for the personal care home was 9 minutes and 41 seconds.

On 7/18/24 the home conducted a fire drill with an evacuation time of 9 minutes and 43 seconds. However, the documentation of a supervised inspection by a fire safety expert dated 10/2/23 indicated the safe evacuation time for the personal care home was 9 minutes and 41 seconds.

On 8/26/24 the home conducted a fire drill with an evacuation time of 9 minutes and 49 seconds. However, the documentation of a supervised inspection by a fire safety expert dated 10/2/23 indicated the safe evacuation time for the personal care home was 9 minutes and 41 seconds.

132d - Evacuation (continued)

On 9/20/24 the home conducted a fire drill with an evacuation time of 9 minutes and 52 seconds. However, the documentation of a supervised inspection by a fire safety expert dated 10/2/23 indicated the safe evacuation time for the personal care home was 9 minutes and 41 seconds.

Plan of Correction ***Accept (- 04/25/2025)***

On 3-28-2025 at approximately 9:00am, the facility had a fire expert come to facility to update the facilities 2600.132 (d) form and 2600.132 (b) form. The update was done to reassess the facility fire safe areas and the safe evacuation time. On 3/28/2025 the 2600.132 (d) form was updated by the fire expert at the facility to reflect that there are No Fire Rated Areas of Refuge, and that all persons must be evacuated outside of the building in case of fire alarm sounding. The Fire Expert also updated the safe evacuation time to 12 minutes 0 seconds, for the design and construction of the building. On 3-28-2025 the facility developed a new form called the Fire Drill Questionnaire. The form will be completed by supervisor of Administrator after every drill. The Form will ask the following questions to be answered: 1. Date and time of Fire Drill. 2. Did facility meet the safe evacuation time Requirement. 3. Were all persons evacuated from the building according to fire experts directive on facility annual 2600.132 (d) form. 4. was the appropriate State form completed for the fire drill and was it filed appropriately.

This form will be kept in the fire drill binder and accompany all of the fire drill documentation. On 3-29-2025 All staff were educated on regulation 2600.132, new Fire drill questionnaire, and the importance of fire safety. On 3-29-2025 the new Fire drill questionnaire was implemented at the facility.

A copy of the new 2600.132 (d) form, the new 2600.132 (b) form, the new Fire drill questionnaire, and the Staff education will be provided in the next step of the POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented (- 04/30/2025)

183b - Meds and Syringes Locked

8. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At approximately 10:21 a.m. in resident room #1 of Swallow Tail belonging to resident #4 there were two three-ounce bottles of miconazole nitrate powder 2.0% that were unlocked, unattended and accessible on the resident's bedside table. One of the two bottles had the lid popped open and the amount of powder remaining in each could not be determined but both were opened. Additionally, there was a four-ounce tube of Medline Remedy Clinical Protect Zinc Oxide paste skin protectant that was approximately three-quarters full and was also found unlocked, unattended, and accessible on the bedside table with the miconazole nitrate powder.

At approximately 10:27 a.m., there were two tubes of ointment or cream with medicated ingredients found unlocked, unattended, and accessible in the top left drawer of the vanity in the resident half-bathroom belonging to resident #4 in resident room #1 of Swallow Tail. The first was an unopened two-point-five ounce tube of Medline Remedy Clinical Treatments anti-fungal ointment with miconazole nitrate 2.0% as an active ingredient. The second tube was Bath & Beauty Diabetic foot cream, a four-ounce tube with approximately three ounces remaining that listed active ingredients of Dimethicone 1% and Petrolatum 30%. Additionally, there was an unopened three-ounce bottle of miconazole nitrate powder 2.0% that was also found in the same drawer in the resident's private half-bathroom.

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

Plan of Correction ***Accept ([redacted] - 04/25/2025)***

On 3-25-2025 at approximately 5:00pm the facility Administrator and facility RN inspected the facility, to ensure that there were no medication in any form unlocked in facility. On 3-28-2025 the facility purchased a new medical cart, which will be designated the Active Care Supply Cart. The Active Care Supply Cart will contain the following items, for all residents at facility: 1. Creams
2. Ointments 3. Powders 4. Pastes 5. Wound supplies
The Active Care Supply Cart will be locked at all times but will be available to all active care staff. Direct care staff will have access to the Active Care Supply Cart, in order to complete active care any time. The new Active Care Supply Cart was implemented on 3-29-2025. On 3-29-2025 the facility developed a new form called the Monthly Room Inspection Form. Two supervisors or one supervisor and the Administrator will complete the form monthly, by rounding the facility to ensure there are no medications unlocked throughout facility. Any item found will be noted on form and reported to the facility Administrator. If an item is found, it will be placed in the residents section of the Active Care Supply Cart, so it may be located and used appropriately. The new Monthly Room Inspection form was implemented on 3-29-2025. On 3-29-2025 all staff were educated on regulation 2600.183, the new Active Care Supply Cart, the new Monthly Room Inspection Form, and the importance of having any medication in any form locked up.
A picture of the new Active Care Supply Cart, a copy of the new Monthly Room Inspection form, and the staff education will be provided at the next step of the POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented ([redacted] - 04/30/2025)

187a - Medication Record

9. Requirements

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

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

Description of Violation

Resident #3 is prescribed Ondansetron HCL 4mg tablet, take one tablet by mouth/sublingually or rectally every 6 hours as needed. However, resident #3's March 2025 medication administration record did not have an area to document the administration of Ondansetron HCL 4mg tablets.

187a - Medication Record (continued)

REPEAT VIOLATION 6/28/24

Plan of Correction ***Accept (- 04/25/2025)***

On 3/24/2025 the Hospice nurse ordered Ondansetron HCL 4 mg tablets for resident #3, who is currently a Hospice patient. The medication was delivered to the facility on 3-24-2025 and placed in the medication cart. The medication was not properly added to the facility EMAR system, although the medication was present in the med cart. On 3-25-2025 at approximately 4:00 pm the Administrator removed the Ondansetron HCL 4 mg from the medication cart. The medication was removed until a physical order could be confirmed and facility could appropriately add to the EMAR system. On 3-27-2025 at approximately 9:00am the Administrator was able to confirm the physical order with the appropriate hospice agency, and successfully added the Ondansetron HCL 4 mg to the EMAR system. On 3-27-2025 at approximately 9:30am the medication was properly placed back into the medication cart.
On 3/26/2025 the facility Administrator and Office Manager reviewed all PRN medications, especially hospice patients to ensure all medications were physically present and also present on the EMAR system.
On 3-29-2025 the facility developed a new form called the New PRN Medication Form. The new form will be completed for every resident who is prescribed an new PRN medication. The new form will include the following information: 1. Residents Name 2. Order Date 3. Name of Medication 4. Pharmacy suppling the medication 5. Date of medication arrival 6. Initials of Staff confirming medication in present in med room 7. Initials of Staff confirming that the medication has been added to the facility EMAR system.
The new PRN Medication Form will accompany all new PRN prescriptions through the new medication process. This will ensure that staff confirms the PRN medication is physically present and that it is on the EMAR system. On 3-29-2025 the New PRN Medication form was implemented at facility. On 3-29-2025 all staff were educated on regulation 2600.187, the new New PRN Medication Form, the POC.
The New PRN Medication form and the Staff education will be provided at the next step of the POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented (- 04/30/2025)

225a - Assessment 15 Days

10. 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

Resident #4's initial assessment, dated , did not include multiple diagnoses indicated on the initial medical evaluation, also dated to include:

- *Constipation*
- *Atrial Fibrillation*
- *Inflammation*
- *Diarrhea*
- *Edema*
- *Depression*
- *Anxiety*
- *Pain*
- *Shortness of Breath*

225a - Assessment 15 Days (continued)

Additionally, resident #4's assessment indicated the resident was moderately immobile, however, resident #4's assessment also indicated the resident is totally dependent for all transfer needs, requires a mechanical lift and is assessed as a two-person assist.

Plan of Correction ***Accept (- 04/25/2025)***

On 3-26-2025 at 1:00 pm the facility Administrator and Office Manager, reviewed all initial assessments, annual assessments, initial medical evaluations, and annual medical evaluations, to ensure all diagnosis and information from all forms matched and did not contradict each other. On 3-26-2025 Resident #4's Assessment and Medical Evaluation were reviewed, and the Assessment was corrected to match the Medical Evaluation with regards to the diagnosis. On 3-26-2025 Resident #4's Assessment was also reviewed in regard to the mobility needs, the Assessment was corrected in order not to be contradicting, in regards to mobility. In 2023 the facility developed a Resident file checklist to accompany every resident file at the facility. The resident file checklist included all of the regulatory items required in a residents file, listed in regulation 2600.252, and also includes anything else that may assist facility in having an regulatory compliant resident file. The resident file checklist is located on the first few pages of every resident file and is completed to ensure all items on the checklist are included and completed in the resident file. On 3-28-2025 the Resident File Checklist was updated to include the following question: Does all the information (including diagnosis) on the Initial assessment or Annual Assessment match the information (including diagnosis) on the resident Initial Medical evaluation or Annual Medical Evaluation?

On 3-29-2025 the new Updated Resident File Checklist was implemented and added into every residents file.

On 3-29-2025 all new Resident Assessments and Medical Evaluations are to be reviewed by the Administrator and either the facility RN, Office Manager, or a supervisor also, in order to catch any mistakes. Both parties will initial the forms to confirm that they are satisfactory and ready to file officially.

On 3-29-2025 all staff were educated on regulation 2600.225, the new Updated Resident File Checklist, and the POC.

A copy of Resident #4's updated Assessment, Updated Resident File Checklist, and Staff Education will be provided in the next step of the POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented (- 04/30/2025)

225c - Additional Assessment

11. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's significant change assessment, dated did not include multiple diagnoses indicated on the initial medical evaluation, dated to include:

- *Constipation*
- *Benign Prostatic Hyperplasia(BPH)*
- *Chronic Obstructive Pulmonary Disease (COPD)*
- *Air hunger*
- *Moderate pain*
- *Nausea vomiting*

225c - Additional Assessment (continued)

- *Major depressive disorder*

Resident #3's annual assessment, dated [redacted] did not include multiple diagnoses indicated on the annual medical evaluation, also dated [redacted] to include:

- *Pruritis*
- *Constipation*
- *Allergies*
- *Pain/fever*
- *Shortness of breath*
- *Seizure activity*
- *Wound healing*
- *Anxiety*
- *Agitation*
- *Rash*
- *Edema*
- *Insomnia*

Resident #5's annual assessment, dated [redacted] did not include diagnoses indicated on the annual medical evaluation, dated [redacted] to include:

- *Cholesterol*
- *Gastroesophageal reflux disease (GERD)*
- *Overactive bladder*
- *Nausea & vomiting*
- *Skin condition*
- *Pain*

However, these same diagnoses also appear on the annual medical evaluation dated [redacted]

REPEAT VIOLATION 2/13/25

Plan of Correction ***Accept ([redacted] - 04/25/2025)***

on 3-26-2025 at approximately 1:00pm the facility Administrator and Office manager reviewed all Resident files to ensure all resident assessments, either initial or annual matched their medical evaluation, either initial or annual. All files were reviewed to ensure that all the diagnosis were noted and that either form did not contradict each other. On 3-26-2025 resident #1, #3, and #5's Assessments and Medical Evaluations were reviewed and corrected so that the Residents Assessments match the Medical Evaluation, in regards of diagnosis. In 2023 the facility developed a form called the Resident File Checklist, this form is located in the first few pages of all residents files. The Checklist is used to make sure all of the regulatory items listed in regulation 2600.252 are present in file and that all steps to assist facility in having an regulatory compliant file are completed properly. On 3-28-2025 the facility updated the Resident File Checklist form to include the following question: Does all of the information (including diagnosis) on the Initial Assessment or Annual Assessment match the information (including diagnosis) on the resident Initial Medical Evaluation or Annual Medical Evaluation?
On 3-29-2025 the new Updated Resident File Checklist was implemented and updated in all resident files.
On 3-29-2025 all new Resident Assessments and Medical Evaluations will be reviewed by the Administrator and

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either the facility RN, Office Manager, or Supervisor also, to ensure mistakes are caught. Both parties will initial the forms to confirm that they are satisfactory and ready to officially filed.
On 3-29-2025 all staff were educated Regulation 2600.225, on the new updated Resident File Checklist, and the POC.
The Resident #1, #3, and #5's Updated Resident Assessments, Updated Resident File Checklist, and the Staff education will be provided at the next step of the POC.

Licensee's Proposed Overall Completion Date: *04/24/2025*

Implemented (- 04/30/2025)