pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail dodonnell@thehearthatdrexel.org
June 2, 2020

Ms. Dana O'Donnell
Administrator
Mary J. Drexel Home
238 Belmont Avenue
Bala Cynwyd, Pennsylvania 19004

RE: The Hearth at Drexel
License #: 140620

Dear Ms. O'Donnell:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 20 and 21, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Shawn Parker

Shawn Parker
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *THE HEARTH AT DREXEL* License Number: *14062*
Address: *238 BELMONT AVENUE,, BALA CYNWYD, PA 19004*
County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

Name: *Dana O'Donnell* Phone: *2156645967* Email: *DODONNELL@THEHEARTHATDREXEL.ORG*

Legal Entity

Name: *MARY J DREXEL HOME*
Address: *238 BELMONT AVENUE, BALA CYNWYD, PA, 19004*

Certificate(s) of Occupancy

Type: *R-3* Date: *03/10/2014* Issued By: *Lower Merion*

Staffing Hours

Resident Support Staff: *82* Total Daily Staff: *207* Waking Staff: *155*

Inspection

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

Inspection Dates and Department Representative

02/20/2020 - On-Site: Sabrina Freeman, Evelyn Perez

02/21/2020 - On-Site: Sabrina Freeman, Evelyn Perez

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* Residents Served: *82*

Special Care Unit

In Home: *Yes* Area: *Inspiring* Capacity: *20* Residents Served: *20*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *82*
Diagnosed with Mental Illness: *3*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *43*
Have Physical Disability: *0*

16c Incident reporting

Requirements

2800.

16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On 5/24/19, resident #1 had a fall and injury which resulted in hospitalization. The home did not report this incident to the Department until 5/26/19.

On 8/21/19, resident #2 had a fall and injury which resulted in hospitalization. The home did not report this incident to the Department until 8/23/19.

On 8/31/19, resident #3 had a fall at 12PM. The resident was taken back to his room and was pronounced deceased at 12:22PM. The home did not report this incident/death to the Department until 9/18/19.

The home did not report the 9/23/19 med-error for resident #6 to the Department until 10/14/19.

The home did not report the 10/16/19 med-error for resident #4 to the Department until 10/18/19.

On 10/13/19, resident #5 fell and hit her head which resulted in hospitalization. The home did not provide documentation or verify that the reportable incident was submitted to the Department.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.16.c

The Hearth at Drexel is aware of the 24-hour reporting requirement for incidents/reportable incidents. All staff have been educated on the requirement/policy. The Director of Nursing will monitor weekly for compliance. Education for this requirement has been added to the nursing training plan and to be signed off by new employees during orientation.

Legal Entity Representative

Dana D'Honncee
Signature

Dana O'Donnell RN Executive Director 3/19/2020
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 06-01-2020 (Date)

Plan of correction implementation status as of 06-01-2020 (Date)

☑ Implemented
☐ Not Implemented

The above plan of correction was approved by SP (Initials)

64c Annual admin training

Requirements

2800.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, the Administrator of the home, was unable to verify 24 hours on annual training in 2019.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.64.c

The Administrator completed 40 plus hours of training. Proof of education is currently in the Administrators employee file. The Administrator is a registered nurse and is required to complete annual education for licensing. Administrator will ensure that all proof of required education is up to date and readily available for survey.

Legal Entity Representative

Signature | Printed Name and Title: Dana D'Darnell RN Executive Director | Date: 3/19/2020

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☑ Implemented
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65e Rights/Abuse 40 Hours

Requirements

2800.
65.e. 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.
5. Safe management techniques.
6. Core competency training that includes the following:
   i. Person-centered care.
   ii. Communication, problem solving and relationship skills.
   iii. Nutritional support according to resident preference.

Description of Violation

The home failed to provide documentation core competency training including nutritional support for staff person B.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.65.e

Employee B has received core competency training, including nutritional support for residents. This is documented in the employees file. The Human resource personnel will audit the employee files to ensure that all training is up to date as needed. The HR personnel will provide an employee training compliance report to the Administrator quarterly.

Admin or designee will ensure all staff have required training for 2800.65e and it is ready and available for agents of the Department in employee files.
SP 06-01-2020

Legal Entity Representative

Signature | Printed Name and Title: Executive Director | Date: 3/19/2020

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☑ Implemented
☐ Not Implemented

65h 16 hrs annual training

Requirements

2800.
65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Direct care staff person C completed only 12.75 hours of annual training during the 2019 training year.

The home could not verify direct care staff person D completed any training for the 2019 training year.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.65.h

All Hearth at Drexel employees are required to have at least 16 hours of annual trainings (additional Dementia-specific trainings as required). The Human resource personnel will audit the employee files to ensure that all training is up to date as needed. The HR personnel will provide an employee training compliance report to the Administrator quarterly. Staff educated on requirement. Employees will not be able to work unless trainings are up-to-date.

Admin or designee will ensure all staff who work within Dementia care units have required training for 2800.65h and it is ready and available for agents of the Department in employee files.

SP 06-01-2020

Legal Entity Representative

Dana Donnell — Signature

Dana Donnell Executive Director — Printed Name and Title

3/19/2020 — Date

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☑ Implemented
☐ Not Implemented

65i Training topics

Requirements

2800.
65.i. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia, cognitive and neurological impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Assisted living service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence.

Description of Violation

Direct care staff person C did not receive training in instruction on meeting resident needs or assisted living service needs of the resident during the 2019 training year.

Direct care staff person D did not receive training in medication self-administration, instruction on meeting resident needs, care of residents with dementia and cognitive impairment, infection control, safe management techniques or assisted living service needs of the resident during the 2019 training year.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.65.i

All Hearth at Drexel employees are required to have the trainings in 2800.65.i annually. The Human resource personnel will audit the employee files to ensure that all training is up to date as needed. The HR personnel will provide an employee training compliance report to the Administrator quarterly. Staff educated on requirement. Employees will not be able to work unless trainings are up-to-date. Admin or designee will ensure all direct care staff have required trainings for 2800.65i and it is ready and available for agents of the Department in employee files. SP 06-01-2020

Legal Entity Representative

Dana D'Arnell — Signature

Dana D'Arnell RN Executive Director — Printed Name and Title

5/19/2020 — Date

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☑ Implemented
☐ Not Implemented

65j Annual training content

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:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).
5. Falls and accident prevention.

Description of Violation

Direct care staff person C did not receive fire safety training by a fire safety expert during the 2019 training year.

Direct care staff person D did not receive fire safety training by a fire safety expert, emergency preparedness, Older Adult Protective Services Act or falls and accident prevention during the 2019 training year.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.65.j

All Hearth at Drexel employees are required to have Fire Safety, Emergency Preparedness training, Resident Rights, The Older Adult Protective Services Act and falls and accident prevention training annually. The Human resource personnel will audit the employee files to ensure that all training is up to date as needed. The HR personnel will provide an employee training compliance report to the Administrator quarterly. Staff educated on requirement. Employees will not be able to work unless trainings are up-to-date.

Admin or designee will ensure all direct care staff have required trainings for 2800.65j and it is ready and available for agents of the Department in employee files. SP 06-01-2020

Legal Entity Representative

Signature | Printed Name and Title: Executive Director | Date: 3/19/2020

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☑ Implemented

☐ Not Implemented

69 Dementia training

Requirements

2800.
69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Direct care staff person C did not receive 2 hours of dementia-specific training during the 2019 training year.

Direct care staff person D did not receive 2 hours of dementia-specific training during the 2019 training year.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.69

All Hearth at Drexel employees are required to have 2 hours of additional Dementia-specific training annually. We have a corporate trainer that is certified by the Alzheimer's Association to provide training for all staff on all aspects of Dementia. The Human resource personnel will audit the employee files to ensure that all training is up to date as needed. The HR personnel will provide an employee training compliance report to the Administrator quarterly. Staff educated on requirement. Employees will not be able to work unless trainings are up-to-date.

Admin or designee will ensure all staff who work within Dementia care units have required training for 2800.69 and it is ready and available for agents of the Department in employee files.
SP 06-01-2020

Legal Entity Representative

Signature

Dana Warner RN Executive Director — 3/19/2020
Printed Name and Title — Date

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☑ Implemented
☐ Not Implemented

82c Locked poisons

Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

One bottle of windex was observed unlocked, unattended, and accessible to resident #10. Resident #10 is on the special care unit and the residents on the special unit have not all been assessed capable of recognizing and using poisons safely.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.82.c

The Hearth at Drexel is aware that poisonous materials shall be kept locked and inaccessible to residents in the Secured Dementia Unit. Family brought in the Windex, family was educated on requirement not to bring in poisonous materials. The community does not use Windex as a product. Resident no longer resides at the Hearth. All staff in-serviced on poisonous material policy. All resident apartments were checked immediately and weekly random apartment checks will be completed by the Director of Nursing to ensure compliance. Room audit documentation will be kept. An email to be sent out to all families regarding poisonous materials requirement/policy.

Legal Entity Representative

Dana DDarrell — Signature

Dana DDarrell RN Executive Director — Printed Name and Title

3/19/2020 — Date

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☑ Implemented
☐ Not Implemented

101j7 Lighting/operable lamp

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

Resident #14 did not have access to a source of light that can be turned on/off at bedside.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.101.j

The Hearth at Drexel is aware of requirement that each living unit must have a source of light that can be turned on/off at bedside. Resident #14 was moving out of the community and removed some furniture from the apartment. All other residents have a light source at bedside. Monthly resident apartment checks will be completed by the Director of Facilities/designee. Audit will be documented and report given to Administrator to ensure compliance.

Legal Entity Representative

Signature

Printed Name and Title: Dana Dowell RN, Executive Director — Date: 3/19/2020

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☑ Implemented
☐ Not Implemented

103i Outdated food

Requirements

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

The following food items were observed unlabeled and undated in the kitchen area and in the food storage.

- Natural Slice Toasted Almonds • Seedless Raisins • Medium Cookie Pieces • Dry Seeds
- 2 Frozen Vegetables Bags • Crackers • Tortilla Chips • Cinnamon Cheerios
- Pasta in a big plastic container • Elbow Pasta

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.103.i

All items were immediately thrown away. Education was provided on requirement for all kitchen staff by the Director of Dining Services. The Director of Dining Services will audit the kitchen weekly to ensure all opened food items are labeled and dated upon opening. Audit logs will be kept and Director of Dining Services will provide report to the Administrator monthly.

Legal Entity Representative

Signature | Printed Name and Title: Executive Director | Date: 3/19/2020

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☑ Implemented
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105g Dryer lint removal

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 2/21/20, lint was observed in the dryer lint trap in the laundry room on the 2nd floor east wing. There were no clothes in the dryer at the time.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.105.g

The lint trap was immediately cleaned upon inspection. Staff was educated 3/21/2020 on regulation. Signs are predominately displayed to remove lint from trap after each use. Director of Facilities/designee will check lint traps daily until 100% compliance is achieved. Once compliance is achieved the lint traps will be checked weekly and randomly to ensure on-going compliance. Documentation of audits will be kept on file by the Director of Facilities.

Staff education to be maintaned by home, and made available for Department review. SP 06-01-2020

Legal Entity Representative

Signature

Dana O'Donnell RN 3/19/2020
Printed Name and Title Executive Director Date

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☑ Implemented
☐ Not Implemented

107d Procedure EMA submission

Requirements

2800.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been reviewed or updated since 3/28/2014.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.107.d

Emergency Procedures are reviewed annually and updated as needed. Emergency Procedure plan was re-submitted to the local emergency management agency. Letter dated 2/20/2020 received from the Regional Manager, Emergency Preparedness; Brian Barth. Documentation will be kept on file of annual review/update dates and submission to emergency management agency by the Director of Facilities.

Legal Entity Representative

Signature | Printed Name and Title: Executive Director | Date: 3/19/2020

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Plan of correction implementation status as of 06-01-2020 (Date)

☑ Implemented
☐ Not Implemented

183b Medications and syringes locked

Requirements

2800.
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 living unit.

Description of Violation

On 2/21/20, medication was observed in resident #13's kitchenette cabinet and bathroom. Resident #13 is on the special care unit and not assessed to self-administer medication.

Medications found unlocked in resident #13's room:

- Unisom Sleep Gel Caps
- Benadryl Itch Stopping Gel / 4 fl onz.
- Derma Daily Moisturizing 222ml.
- Calmoseptine Ointment 113gm.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.183.b

All items were removed immediately from the resident's apartment. Staff was educated on 3/21/2020 and will be on-going. Family updated not to leave items in the apartment and to give to staff. All resident apartments were checked immediately and weekly random apartment checks will be completed by the Director of Nursing to ensure compliance. Room audit documentation will be kept.

Legal Entity Representative

Signature

Printed Name and Title Dana O'Donnell RN Executive Director

Date 3/19/2020

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Plan of correction implementation status as of 06-01-2020 (Date)

☑ Implemented
☐ Not Implemented

183d Current medications

Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 2/17/20, the Scopolamine that was prescribed for resident #11 was discontinued. The medication was still on the cart on 2/21/20, in addition the prescription label read discard 12/26/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.183.d

Prescription was removed immediately and discarded properly. All medication carts were checked to ensure that only current ordered medication was present. Monthly medication cart audits will be completed by the Director of Nursing/designee and documentation will be kept to ensure compliance. All responsible clinical staff was educated on requirement 2/21/2020.

Legal Entity Representative

Signature

Printed Name and Title

Date

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☑ Implemented
☐ Not Implemented

185a Storage procedures

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 #11 is prescribed Mylanta every 12 hours as needed. On 2/21/20, the medication was not available in the residence.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.185.a

Resident #11's family provides over the counter medication. Family was updated on need for medication. Medication was received the evening of 2/21/2020. In the event that family does not provide ordered over the counter medication, the clinical staff will update the doctor and follow orders as prescribed. Clinical staff was educated and directed to inform Director of Nursing of missing medication. Director of Nursing will contact family/POA and receive approval to utilize the Hearth pharmacy for the medication. Documentation will be recorded in the clinical record.

Legal Entity Representative

Signature

Dana Donnell Executive Director 3/19/2020
Printed Name and Title Date

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☑ Implemented
☐ Not Implemented

187d Follow prescriber's orders

Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #9 is prescribed Ensure at lunch. Resident #9 did not receive Ensure on 2/13, 2/15, 2/16, 2/17, 2/18, 2/19 or 2/20/20 as it was not available in the home. Resident #9's family supplies the Ensure.

Additionally, resident #9 is prescribed two tablets of 500mg Acetaminophen three times a day. Resident #9 was not administered the medication on 2/16 or 2/17/20 at 9AM, 1PM or 8PM as the medication was not available in the home.

Resident #10 is prescribed Ensure twice a day. Resident #10 did not receive Ensure on 2/17, 2/18 or 2/19/20 at 10AM or 2PM as it was not available in the home. Resident #10's family supplies the Ensure.

Resident #11 is prescribed Synthroid in the morning. Resident #11 was not administered the medication on 2/6/20 at 5AM.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.187.d

The Hearth at Drexel is aware of all prescribed prescriptions are to be administered as ordered. Both families were updated that Ensure needs to be available or we will use house stock. Staff were instructed to inform families/POA when supplies are getting low to ensure enough time to receive items/medications and to inform Director of Nursing when items are not available to be administered. We have increased the house supply of certain items (Ensure) to comply. The Medication Administration Record will be audited weekly for completion. The Director of Nursing will monitor monthly and documentation will be kept.

Legal Entity Representative

Dana Odonnell
Signature

Dana O'Donnell RN Executive Director
Printed Name and Title

3/13/2020
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

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The above plan of correction was approved by SP (Initials)

Plan of correction implementation status as of 06-01-2020 (Date)

☑ Implemented
☐ Not Implemented

234a Admission – support plan

Requirements

2800.
234.a.1. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the special care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #5 was admitted to the special care unit on 10/2/19. Resident #5's initial support plan was completed on 10/13/19.

Resident #10 was admitted to the special care unit on 5/13/19. Resident #10's initial support plan was completed on 5/17/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.234.a.1

The Hearth at Drexel will ensure compliance with the regulation. All Support Plans will be completed, implemented and documented in the resident's record within 72 hours of admission or within 72 hours prior to admission to the SDU. The Director of Nursing will be responsible for ensuring that the regulation is followed and in compliance. All admission records to the SDU will be audited within 48 hours for compliance. Staff has been educated on regulation. This item will be added to the clinical orientation checklist and the admission checklist.

Legal Entity Representative

Signature

Dana O'Donnell Executive Director 3/19/2020
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 06-01-2020 (Date)

The above plan of correction was approved by SP (Initials)

Plan of correction implementation status as of 06-01-2020 (Date)

☑ Implemented
☐ Not Implemented

252 Records – content

Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.

Description of Violation

Resident #7's record does not include the 1/3/20 reportable incident.

Resident #8's record does not include the 2/20/20 reportable incident.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2800.252

All past Reportable Incidents will be added to all resident records by 4/15/2020. All new reportable incidents will be placed it the residents clinical records. The Director of Nursing will ensure compliance. All reportable incidents are to be reviewed weekly by the Director of Nursing. A log is kept of all incidents and reportable incidents for monitoring.

Legal Entity Representative

Dana Donnell | Dana Donnell RN Executive Director | 3/19/2020

Signature | Printed Name and Title | Date

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