pennsylvania
DEPARTMENT OF HUMAN SERVICES

# CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **TAPESTRY MOON LLC**
LEGAL ENTITY

To operate **TAPESTRY SENIOR LIVING MOON TOWNSHIP**
NAME OF FACILITY OR AGENCY

Located at **550 CHERRINGTON PARKWAY, CORAOPOLIS, PA 15108**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE



To provide **Assisted Living-Special Care**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **104**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Special Care Unit - 55 Pa.Code §§ 2800.231-239 - Capacity 71**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

**55 Pa.Code Chapter 2800: Assisted Living Residences**
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 18, 2020** until **February 18, 2021**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **450092**

Robert E. Robinson
ISSUING OFFICER

Jamie L. Buchenauer
DEPUTY SECRETARY

**NOTE:** This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 6/20

pennsylvania
DEPARTMENT OF HUMAN SERVICES

**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**
**MAILING DATE:** September 1, 2020

Ms. Teresa Pawlina
President
Tapestry Companies, LLC
2001 Killebrew Drive, Suite 100
Minneapolis, Minnesota 55425

RE: Tapestry Senior Living Moon Township
550 Cherrington Parkway
Coraopolis, Pennsylvania 15108
License #: 450092

Dear Ms. Pawlina:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on October 4, 2019; October 10, 2019; October 25, 2019; January 2, 2020; January 3, 2020 and January 15, 2020, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), the Department hereby REVOKES your certificate of compliance (450091) dated September 9, 2019 to March 9, 2020, and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from August 18, 2020 to February 18, 2021.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jamie L. Buchenauer
Deputy Secretary
Office of Long-Term Living

Enclosure
License
Licensing Inspection Summary

# Violation Report

## Facility Information

**Name:** *Tapestry Senior Living Moon Township* **License Number:** *45009*
**Address:** *550 Cherrington Parkway, Coraopolis, PA 15108*
**County:** *ALLEGHENY* **Region:** *WESTERN*

## Administrator

**Name:** *Anne Giehl* **Phone:** *412-480-4904* **Email:** *anne.giehl@tapestrysenior.com*

## Legal Entity

**Name:** *TAPESTRY COMPANIES, LLC*
**Address:** *2001 KILLEBREW DRIVE SUITE 100, MINNEAPOLIS, MN, 55425*

## Certificate(s) of Occupancy

**Type:** *I-1* **Date:** *07/29/2019* **Issued By:** *TWP OF MOON*

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *94* **Waking Staff:** *71*

## Inspection

**Type:** *Partial* **BHA Docket #:** **Notice:** *Unannounced*
**Reason:** *Complaint*

## Inspection Dates and Department Representative

*10/04/2019 - On-Site: Josh Hoover, Vicki Siegert, Barbara Barone, Lisa Flinner-Alman*

*10/10/2019 - On-Site: Josh Hoover, Vicki Siegert*

*10/25/2019 On Site: Josh Hoover, Vicki Siegert*

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *104* **Residents Served:** *59*

### Special Care Unit

**In Home:** *Yes* **Area:** *Floors 1-4* **Capacity:** *71* **Residents Served:** *26*

### Hospice

**Current Residents:** *NA*

### Number of Residents Who:

**Receive Supplemental Security Income:** *0*
**Are 60 Years of Age or Older:** *59*
**Diagnosed with Mental Illness:** *0*
**Diagnosed with Intellectual Disability:** *0*
**Have Mobility Need:** *35*
**Have Physical Disability:** *0*

## 5a1 DHS access

### Requirements

**2800.**

**5.a.** The administrator, administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall provide, upon request, immediate access to the residence, the residents and records to:

**1.** Agents of the Department.

### Description of Violation

On 10/4/2019, resident and staff records were requested at approximately 9:30a.m. At approximately 11:00a.m, only portions of the requested records were received, including resident contracts and medical evaluations. Full records were again requested at this time, including assessments, support plans, and medication administration records (MARs). At approximately 12:20p.m. incomplete paper records were provided, and not until approximately 12:40p.m. was computer access to electronic records provided. Assessments and support plans were not provided until approximately 1:00p.m. MARs were not provided until approximately 4:00p.m. Staff training records and criminal background checks were not provided until 10/10/2019 at approximately 4:00p.m.

### 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.)

Sincere apologies. The issue of untimely access to clinical records has been addressed by the Clinical Director. The Regional QA Director has provided on site additional software training to the Clinical Director and additional nursing staff including the eMar system, as well as printing feature of all documents/reports. This will allow the Clinical Director and her staff to print requested documents with ease. Additionally, audits were preformed of the paper charts to ensure uniformity and completeness of the resident's record. Both paper and electronic records are audited monthly by nursing staff (Assistant DCS and Nursing Office Manager)on site and by our Regional QA Director (RN)on a monthly basis to reverify the completeness of the resident record for the next quarter.
In addition, the untimely access to staffing records has been address by the Administrator/Business Office Director (BOD), who has performed a 100% audited of the employee files for completion. Training records are now kept in each employee file rather than a binder for easier inspection. Monthly audits by will be performed by the business office staff, overseen by BOD. As well, Corporate office will perform quarter audits and more frequent to reverify the completeness of all records.
The administrator or designee will ensure access to resident records are provided immediately, upon request to agents of the Department. - JRW 12/31/19

### Legal Entity Representative

Anne Giehl

Signature

Printed Name and Title ANNE GIEHL EXEC. DIRECTOR

Date 12/21/19

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 25b Contract signatures and renewal

### Requirements

2800.
**25b .** The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

### Description of Violation

The resident-residence contract for resident #1, dated 8/14/2019, is not signed by the resident.

The resident-residence contract for resident #2, dated 9/11/2019, is not signed by the resident or the administrator or designee.

### 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.)

The Administrator has made these corrections and audited all resident files to ensure required signatures are present. Additionally, a policy and procedure has been implemented with the Business Office Director checking for compliance with 2800.228 (using a compliance checklist) prior to inputting the resident into the billing system. The Chief Operating Officer also completes resident file audit quarterly.

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 12/31/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20

☐ Implemented

☒ Not Implemented

## 51 Criminal background checks

### Requirements

**2800.**

**51.** Criminal background checks

**a.** Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

**b.** The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

### Description of Violation

No criminal history background checks have been completed for the following direct care staff:

-Staff person A, hired 7/22/2019

-Staff person B, hired 8/19/2019

-Staff person C, hired 7/29/2019

### 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.)

Tapestry utilizes a globally recognized and endorsed, third party applicant screening company, Certiphi, for all of our preemployment testing including criminal history checks. Certiphi does run applicants through the PA State Police, PATCH, background check in accordance to the Department of Aging's Older Adult Protective Services Act policy as indicated in the employee files of Staff persons A, B and C above. Attached are those reports and additional supporting documentation from Certiphi to illustrate compliance.
The Business Office Director will continue to utilize Certiphi for our background screening and include supporting documentation in employee files.

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 60a Staffing/support plan needs

### Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

### Description of Violation

On 9/14/2019, the residence served 32 residents, including 15 residents with mobility needs, including 11 residents in Secured Care Units (SCUs) on 3 separate floors, and 1 resident who requires the assistance of 2 staff persons to transfer. Only 3 staff persons worked from 12:00a.m. and 6:20a.m. In the event of an emergency, there was insufficient staff to safely evacuate residents.

### 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.)

Oddly, the staffing documentation for 9/14/19 was not located for surveyors at the time of inspection. However, all other requested staffing were available for inspection and showed ample staff available for all shifts and all residents to the resident needs safely, effectively and meet the mobility needs of residents. Staffing levels are monitored on an ongoing basis (daily and by each shift) by the Clinical Director, Sharyce Greene, RN, Charge/supervisory nurse (of each shift) and Administrator to ensure residents needs and services are are met and performed safely and effectively. Staffing is evaluated prior to any new resident move-in/admissions to elevate if additional staff will be needed. The evaluation of staffing is a continuous and ongoing process. The safety of residents is the highest priority to leadership and our staffing reflects that.

### Legal Entity Representative

| Signature | Printed Name and Title | Date |
|---|---|---|
| Anne Giehl | ANNE GIEHL, EXEC. DIRECTOR | 12/21/19 |

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 65a Fire Safety-1st day

### Requirements

2800.

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

Direct care staff person B, hired 8/19/2019, did not receive training in any of the topics required under § 2800.65(a).

### 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.)

The Administrator immediately trained staff person B on the topics required under 2800.65a, documentation of this training and is in the employee file.
In addition, all employee files were audited by the Administrator/designee; any training that was missed was completed by appropriate leadership and documented in employee file(s).
A training checklist for new employee orientation was created to ensure all topics under 2800.65a are trained and have shown competence prior to working independently regarding completing their respective tasks.
The Administrator and Clinical Director (RN) performed and in-service with all community leadership to review the policies above and the training protocol for all staff. Please find in service attendance and policies.

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 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**

Direct care staff person B, hired 8/19/2019, did not receive training in any of the topics required under § 2800.65(b).

The following direct care staff persons did not receive training on the emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, or reporting of reportable incidents and conditions:

Staff Person D, hired 10/1/2019

-Staff Person E, hired 9/18/2019

The following direct care staff persons did not receive training on the emergency medical plan or reporting of reportable incidents and conditions:

-Staff Person A, hired 7/22/2019

Staff Person C, hired 7/29/2019

-Staff Person F, hired 7/29/2019

**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.)

The Administrator and Business Office Director have audited all employee files for compliance with 2800.65e. Additional training with documentation was provided to staff and the online training platform, Relias has been instituted for compliance. Likewise, Agency staff was given required orientation training.
The Administrator and/or Clinical Director (RN) performed and in-service with all community leadership to review the training protocol for all staff. Please find in service attendance and protocol.
The Business Office Director ensures that all required training is done and documented in employee file.

**Legal Entity Representative**

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

## 65e Rights/Abuse 40 Hours *(continued)*

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

The above plan of correction is approved as of 12/31/19 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented

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

☒ Not Implemented

## 65g Initial direct care training

### Requirements

2800.

65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with mental illness, neurological impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the residence.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. The signs and symptoms of infections and infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the residence.
   - xvii. Behavioral management techniques.
   - xviii. Understanding of the resident's assessment and how to implement the resident's support plan.
   - xix. Person-centered care and aging in place.

### Description of Violation

Direct care staff person B, hired 8/19/2019, did not receive any of the training required under § 2800.65(g) prior to providing unsupervised assisted living services.

Direct care staff person D, hired 10/1/2019, and direct care staff person E, hired 9/18/2019, received only 4 hours of initial training prior to providing unsupervised assisted living services.

### 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.)

The Administrator and Business Office Director performed an 100% audited of employee files for compliance with 2800.65g. Additional training with documentation was provided to staff and the online training platform, Relias has been instituted for compliance with additional RN/LPN dementia trained on-site training as needed. Substitute staff who's Agency was not able to provide documentation of required training were provided training or discontinued in the community.
The Human Resources Assistant will ensure that all required training is performed with supporting documentation placed into the employee file. The Business Office Director (BOD) will perform monthly for the completeness of the employee file and Quarterly Audits will be performed by the COO/designee for verification of compliance.



12/31/19

## 65g Initial direct care training *(continued)*

**Legal Entity Representative**

| Signature | Printed Name and Title | Date |
|---|---|---|
| Anne Giehl | ANNE GIEHL, EXEC. DIRECTOR | 12/21/19 |

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

The above plan of correction is approved as of 12/31/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

[X] 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

The following staff persons have not received any dementia specific training:

-Staff person B, hired 8/19/2019

-Staff person D, hired 10/1/2019

-Staff person E, hired 9/18/2019

### 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.)

The Administrator and Business Office Director (BOD) have audited all employee files for compliance with 2800.69. Additional training with documentation was provided to staff and the on-line training platform, Relias has been instituted for compliance with on-site RN/LPN dementia training provided individually to staff as needed. Likewise, Agency staff was given required dementia training or discontinued from service in the community.
The Human Resources Assistant will ensure that all required training is performed with supporting documentation placed into the employee file. The Business Office Director (BOD) will perform monthly for the completeness of the employee file and quarterly audits will be performed by the COO/designee for verification of compliance.

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 12/31/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented

☒ Not Implemented

## 81a Disability accommodation

### Requirements

2800.
81.a. The residence shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the residence.

### Description of Violation

The 2nd, 3rd, and 4th floor SCUs are constructed around the open-air atrium at the center of the building that extends from the roof to ground level. There are 5 large openings approximately 48 inches high and from between 5 feet to 8 feet wide in each SCU open corridor overlooking the atrium. The only only barrier between the open corridor and the atrium is a half-wall measuring 45 inches tall. There are no fall precautions or other safety barriers to prevent a resident from climbing or falling to ground level below. Residents of the residence have not been assessed for their ability to safely navigate the hazardous open corridor with fall risk.

On 10/4/19, there were no grab bars for toilets in both the men's and women's restroom or the urinals in the men's restroom in the public bathrooms near the senior center. The only grab bars in these bathrooms were in the handicap accessible stalls.

On 10/10/19, there were no grab bars for the toilets and urinals in the men's and women's locker rooms near the pool area, except in the handicap accessible stalls.

### Plan of Correction (POC)

The proposed plan of correction for this violation is to increase the height of the 45 inch tall walls to 62 inches tall for all the open areas listed above. The increased height will be accomplished by installing a railing installed upon the half walls consistent with other areas in the building. Please see the attached drawings to illustrate this proposal.
Residents to be supervised in this area until barrier completion. - JRW 1/8/20
Upon approval from the Department for this POC, the administrator will immediately contract vendors to complete the installation of the additional railings with a completion date within 90 days of your approval.

The administrator questions this violation as the regulation does not specify that grab bars must be installed in all restroom stalls and implies requirement is for the resident apartments. The home does have grab bars in each residents' private apartment. The home has a handicapped accessible stall in each public restroom and additional family style restrooms that are ADA compliant. The public restrooms met building codes and offer a adequate number of public bathrooms grab bars (specifically 14 stalls) for the 4 PHC residents. See picture of resident restrooms and grab bars in each public bathroom.

### Legal Entity Representative

Anne Giehl
Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19
Printed Name and Title Date

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

The above plan of correction is approved as of 1/10/20 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

☐ 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

On 10/10/2019, there were multiple poisons with manufacturers' labels indicating, "if swallowed, contact a physician or poison control," unlocked, unattended and accessible, including a 5-gallon bucket of Xypex concrete waterproofing, numerous 5-gallon buckets of laundry soap, a 1-gallon bottle of Xypex gamma cure curing compound, and numerous cans of paint, stain, and other construction finishing materials, located in the unlocked, unattended, and accessible ground floor rear hallway. Located in this hallway are the laundry room, pool area, locker rooms, and other storage.

None of the residents have been assessed for the ability to safely use or avoid poisonous materials.

### 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.)

On 11/29/19, the Maintenance Director disposed of the above listed chemicals and did a complete walk through of the building to ensure that no other chemicals were accessible to residents or potential visitors. The administrator performed an educational in-service/training with all department directors, managers and staff on safe practices with chemical and poisons, including the handling and storage of such substances. See attached policy and attendance roster. In addition, Sharyce Greene RN, and licensed nursing designee, assess current resident's ability to use/avoid poisonous materials and moving forward all new residents will be assessed and have this information documented on their respective ASP. This assessment will be kept in resident charts and updated annually or with change of condition.

All poisons will be kept in locked areas. - JRW 12/31/19

### Legal Entity Representative

Anne Giehl
Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19
Printed Name and Title Date

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 88a Floors, walls, ceilings, windows, doors

### Requirements

**2800.**
**88.a.** Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

### Description of Violation

There is an expansive water feature on the ground floor of the home, with a waterfall, pools, rocks, and various hardscape on multiple levels. Directly opposite the main entrance, an area of the water feature measuring approximately 22 feet wide has no railing or other precautions to prevent falls. The main floor of this area leads to a stone border approximately 5 inches tall before giving way to a drop of approximately 24 inches into water that is approximately 12 inches deep. None of the residents of the residence have been assessed for safety around this water feature.

On 10/10/2019, the rear hallway of the ground floor was unlocked, unattended, and accessible by multiple doors. Maintenance work was being completed on the elevator in this hallway, There were no safety barriers present. An area of the hallway measuring approximately 4 feet by 7 feet was littered with numerous tools, boxes, and looped extension cords. The elevator doors were open and the elevator shaft was accessible.

On 10/10/2019, the hallway leading to the swimming area was unlocked and unattended and there was no operable lock on the door to the swimming pool area. Access to the swimming area was unimpeded. There was no water in the pool, and it is 4 to 6 feet in depth. The pool area was under construction and surrounded by storage boxes, tools, paint, and other construction materials, posing trip/fall hazards. Residents have not been assessed for safety in the swimming area. The home's policy for the swimming area indicates "the swimming pool is in a locked area, accessible only with an assigned key. Residents may use it at their own risk in accordance with their medical evaluation and care plan."

### 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.)

On 10/11/19, the multiple doorways allowing access to the area affected by an elevator repair were closed off to residents to ensure their safety. An in-service provided by the administrator to the maintenance director and maintenance staff on isolating and securing work areas from residents/staff was performed to prevent unsafe areas moving forward. Attached is the in-service and attendance record.

The proposed POC for the water feature is to install a landscaping buffer area to isolate the water feature. Attached is an illustration of our proposal. Upon the Department's acceptance of this proposal, the administrator will hire vendors to install the landscaping with a completion date of 90 days from your approval.

Sharyce Greene, RN or designee will assess each resident for safety around water by December 21. The assessment will be kept in the resident chart and reassessed annually and/or with a change of condition.
10/11/19, the maintenance director locked the pool access door to all residents. This door will remain locked while unattended until the pool construction is completed and the pool is entered into service. Anticipated completion and opening of the pool is slated for January 2020.

By 12/31/2019, key card operated mag locks will be installed by independent contractor, Telephonix to secure the pool area. Prior to opening and granting access keys to able residents, Sharyce Greene, RN or designee will assess all residents for safety around water. The assessment will be kept in the resident chart and reassessed annually or upon change of condition.

### Legal Entity Representative

Anne Giehl
Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19
Printed Name and Title Date



12/31/19

## 88a Floors, walls, ceilings, windows, doors *(continued)*

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

The above plan of correction is approved as of 12/31/19 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented

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

☒ Not Implemented

## 101i Access

### Requirements

2800.
101.i. A resident shall have access to his living unit at all times.

### Description of Violation

Every living unit in the residence is equipped with automatic electronic locks and doors that automatically close. A key card is required to requires the use of a key-card to enter the living unit. Not all residents in the SCUs have the cognitive capacity to carry or utilize these key cards, including residents #2, #3, and #4, and as a result, they do not have access to their living units.

### 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.)

Residents always have access to their living units as the SCU unit is staffed 24 hours a day to assist residents with assisted living services such as escorts and basic cognitive support services which include verbal cueing, redirection and environmental cues (2800.4). Staff routinely utilized these supports in the SCU to physically assist residents into their rooms, cued residents on how to use the key card, or used an environmental cue such as a sign to signal the staff and resident to leave the door open until requested otherwise.
As a direct result of this violation, the maintenance director has turned off the electronic locks in the SCU. A key, regardless of type (card or traditional) carries the same challenge for residents in the SCU who have limited cognitive capacity to carry and utilize a key resulting in the perception of limited access to their living units.

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 121a Unobstructed egress

### Requirements

**2800.**
**121.a.** Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

### Description of Violation

On 10/10/2019, the 2 metal gates in the small outdoor patio area leading from the emergency exit behind the swimming pool were locked, preventing egress from this part of the building.

### 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.)

On 11/29/19, the locks on the metal patio gates off the pool were removed by independent contractor Terry Sparrow. By 12/15/19 new latches were installed by independent contractor Terry Sparrow on the courtyard patio gate to allow unobstructed egress.

By 7/15/20 - A designated staff person will monitor the emergency exits at least daily to ensure they remain unlocked and unobstructed. - JRW 6/15/20

### Legal Entity Representative

Anne Giehl
Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19
Printed Name and Title Date

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

The above plan of correction is approved as of 6/15/20 (Date)

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

Plan of correction implementation status as of 6/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 123a Exit doors

### Requirements

**2800.**
**123.a.** Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

### Description of Violation

On 10/10/2019, the two exit doors from the 2nd, 3rd, and 4th floor SCUs that lead to stairwells A and D were equipped with magnetic locks that could only be opened with the use of a key-fob.

REPEAT VIOLATION: 8/8/2019

### 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.)

10/13/19, all magnetic locks were replaced with keypads as indicated in a previous, approved POC dated (8/20/19). The scope of the work was completed on 10/13/19 by independent contractor Silversphere. Residents/visitors/staff can now operate the locks with a key fob and/or manually with a posted code. See pictures.

By 7/15/20 - A designated staff person will monitor the locks at least daily to ensure the keypads are functional ant the exit code is posted.. - JRW 6/15/20

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 6/15/20 (Date)

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

Plan of correction implementation status as of 6 /15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 133.1 Exit signs

### Requirements

2800.
133.1. Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

### Description of Violation

On 10/10/2019, there were no exit signs posted at the main doors of the 2nd, 3rd, and 4th floor SCUs.

### 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.)

By 12/21/19, the maintenance director installed exit signs to provide direction of travel to exit the 2nd, 3rd, and 4th floor SCUs as depicted on the evacuation diagram posted in the neighborhood.

Maintenance staff will monitor the signs monthly to ensure they remain in place. - JRW 12/31/19

All staff will be educated on exit signs and locations for regulation 2800.133.1.- JRW 12/31/19

### Legal Entity Representative

Anne Giehl
Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19
Printed Name and Title Date

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 141a Medical evaluation

### Requirements

2800.

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
12. Information about a resident's day-to-day assisted living service needs.

### Description of Violation

The medical evaluation for resident #1, admitted 9/12/2019, was completed on 6/7/2019.

The medical evaluation for resident #5, dated 9/10/2019, does not indicate if the resident has had a tuberculin skin test in the past 2 years.

The medical evaluation for resident #6, dated 7/19/2019, does not indicate if the resident has had a tuberculin skin test in the past 2 years and was completed more than 60 days prior to her date of admission of 9/21/19.

### 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.)

Nursing Staff re-trained to ensure that all medical evaluations are completed by the residents primary care physician/medical provider in accordance with the regulations. If the timeframe exceeds the allowable time. The resident will be requested to have a follow up medical evaluation on prior to move-in. A new dedicated RN pre-admission position has been created to ensure this responsibility. Documentation that is incomplete or missing information is returned to physician and a re-assessment of the resident is requested. Resident Service Director Sharyce Greene, RN or the appropriate designee reviews all admission paperwork prior to move-in to ensure paperwork is appropriate prior to move-in. Residents without documentation of TB test within the last 2 years will be required to have testing done within 15 days of admission. A Nursing Office Manager, Tandra Jones has also been hired and will assist with auditing charts to ensure ongoing compliance with documentation.

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

## 141a Medical evaluation *(continued)*

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

The above plan of correction is approved as of 12/31/19 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

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

[X] Implemented

[ ] Not Implemented

## 184a Labeling

### Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

### Description of Violation

Resident #2 is ordered Albuterol 0.083%, inhale contents of one vial via nebulizer one to two times daily; however, the label for this medication indicates "inhale contents of one vial via nebulizer two times daily."

Resident #2 is ordered Dorzolamide HCL 2% eye drops, instill one drop into left eye twice daily; however, the label for this medication does not include the prescribed dosage or instructions for administration.

### 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.)

Inaccuracies were discovered regarding orders and pharmacy labels. Nursing has been inserviced/educated to check all incoming medications to ensure labels have necessary information and are accurate with the orders we have on file. Discussed with Pharmacy these inconsistencies - in accordance with best practices the Pharmacy populates the MAR, labels and dispenses the medication according to the prescribed medication orders that are provided to them. The nurse will perform a double check when medications are received from Pharmacy and report any discrepancies to the Resident Service Director [redacted] RN. Staff have also been educated of labeled medications bought in by family that do not match medication orders on file will not be accepted to prevent similar issues from occurring in the future. Medication Cart audits have been performed and reconciliation of all medications have been found to be labeled appropriately. [redacted] RN and/or her appropriate designee will do monthly medication audits to ensure labels remain consistent with current orders.

### Legal Entity Representative

Anne Giehl
Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19
Printed Name and Title Date

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

The above plan of correction is approved as of 12/31/19 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

The above plan of correction was approved by (Initials)

[ ] Not Implemented

## 184b Resident meds labeled

### Requirements

2800.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

### Description of Violation

Aspirin 81mg, Preservision Areds 2, and Sodium Chloride belonging to resident #4 are not labeled with the resident's name.

### 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.)

An inservice was completed on 12/23/19 regarding the need for all medications that belong to a specific resident be identified with the residents name. Inservice also includes that OTC medications not previously/appropriately labeled by the pharmacy shall be identified with the residents name by nursing staff when received. Cart audits were completed by Resident Service Director and her designees on (date) to ensure that current medications are all appropriately labeled and identified with the residents name. Random cart audits will be conducted no less than monthly by [redacted] RN or her designee to ensure ongoing compliance.

### Legal Entity Representative

Anne Giehl
Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19
Printed Name and Title Date

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

The above plan of correction is approved as of 12/31/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

[X] 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 #2 is ordered Lorazepam 0.5mg, take 1 tab every 8 hours as needed for anxiety. This medication was not available in the residence on 10/25/19.

### 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.)

In-service completed 12/23/19 with nursing staff regarding the need to have all PRN orders available for administration. The educational in-service will include that any resident/guardian concerns or discrepancies regarding medication/treatment orders will be clarified with the residents PCP and communicated to all parties appropriately and written as a "requesting clarification order" to the medical provider for written confirmation. The nurse will complete an incident report and notify the pharmacy of the lack of available medication; the Office Manager will fax to the pharmacy and medical provider regarding the lack of the available medication and the nurse will document in the resident chart. Within 24 hours a subsequent notification will be sent to pharmacy, medical provider and family if the medication has still not been received. Daily notification will be sent to pharmacy, medical provider and family until acknowledgment and resolution/medical orders received as to the next step of action. The lack of availability of greater than 24 hours will be reported to the Resident Service Director [redacted] RN and her designee to ensure the availability of all ordered medications and for additional action if warranted.

Additional audits no less than monthly will be completed by [redacted] RN and/or her designee to ensure ongoing compliance and to identify trends of problem areas (type of medication, provider or staff). Incident report will be completed on each missed medication for further evaluation.
Medication Cart audits no less than monthly will be completed [redacted] RN and/or her designee to ensure ongoing compliance, as well as quarterly pharmacy led cart audits. Corporate Regional QA Director (RN) will verify quarterly compliance with this requirement through on-site audits of compliance.

Resident #4's Lorazepam reordered and present in the home. - HRW 6/15/20

### Legal Entity Representative

Anne Giehl — ANNE GIEHL, EXEC. DIRECTOR 12/21/19

Signature | Printed Name and Title | Date

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

The above plan of correction is approved as of 6/15/20 (Date)

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

Plan of correction implementation status as of 6/15/20 (Date)

_ Implemented

X Not Implemented

RECEIVED
JANUARY 22 2020
WEST REGION FIELD OFFICE
Human Services Licensing



## 187c Refusal to take medication

### Requirements

2800.
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

Resident #4 is ordered Sodium Chloride 1gm, take one by mouth twice daily. Resident #4 refused this medication at 8:00a.m. on 10/4/2019, 10/10/2019, 10/13/2019, 10/14/2019, 10/15/2019, 10/16/2019, 10/18/2019, 10/22/2019, 10/24/2019, and 10/25/2019. The prescriber was not notified of the refusals.

### 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.)

[redacted] RN did an in service with nursing staff on 1/17/2020. Nursing staff will notify resident's physician and responsible party after the refusal of medication by the resident.

Resident #4's physician was notified of medication refusals and the physician discontinued the medication. JRW6/15/20

### Legal Entity Representative

Anne Gienl — Signature

Anne Gienl, Executive Director — Printed Name and Title

1/22/2020 — Date

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

The above plan of correction is approved as of 6/15 2020 (Date)

Plan of correction implementation status as of 6/ '15/20 (Date)

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

[X] Implemented

[ ] Not Implemented

## 187d Follow prescriber's orders

### Requirements

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

### Description of Violation

On 10/21/2019 at 8:00p.m resident #2 did not receive the following prescribed medications as they were not available in the residence: Albuterol 0.083%, inhale contents of one vial via nebulizer 1 to 2 times daily, Dorzolamide HCL 2% eye drops, instill one drop into left eye twice daily, Latanoprost .005% eye drops instill one drop into bilateral eyes at bedtime,and Montelukast Sodium 10mg, 1 daily at bedtime.

On 10/9/2019, resident #7 did not receive the following prescribed medications as they were not available in the residence: Levothyroxine 75 mcg, 1 daily, and Omeprazole 20 mg, 1 daily.

### 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.)

In-service completed 12/23/19 with nursing staff regarding the need to have all PRN orders available for administration. The educational in-service will include that any resident/guardian concerns or discrepancies regarding medication/treatment orders will be clarified with the residents PCP and communicated to all parties appropriately and written as a "requesting clarification order" to the medical provider for written confirmation. The nurse will complete an incident report and notify the pharmacy of the lack of available medication and the Office Manager will fax to the pharmacy and medical provider regarding the lack of the available medication and the nurse will document in the resident chart. Within 24 hours a subsequent notification will be sent to pharmacy, medical provider and family if the medication has still not been received. Daily notification will be sent to pharmacy, medical provider and family until acknowledgment and resolution/medical orders received as to the next step of action. The lack of availability of greater than 24 hours will be reported to the Resident Service Director [redacted] RN and her designee to ensure the availability of all ordered medications and for additional action if warranted.

Additional audits no less than monthly will be completed by [redacted] RN and/or her designee to ensure ongoing compliance and to identify trends of problem areas (type of medication, provider or staff). Incident report will be completed on each missed medication for further evaluation.
Medication Cart audits no less than monthly will be completed [redacted] RN and/or her designee to ensure ongoing compliance, as well as quarterly pharmacy led cart audits. Corporate Regional QA Director (RN) will verify quarterly compliance with this requirement through on-site audits of compliance.

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented

☒ Not Implemented

## 224a5 Written initial assessment

### Requirements

**2800.**
**224.a.5.** The written initial assessment must, at a minimum include the following:

- **i.** The individual's need for assistance with ADLs and IADLs.
- **ii.** The mobility needs of the individual.
- **iii.** The ability of the individual to self-administer medication.
- **iv.** The individual's medical history, medical conditions, and current medical status and how they impact or interact with the individual's service needs.
- **v.** The individual's need for supplemental health care services.
- **vi.** The individual's need for special diet or meal requirements.
- **vii.** The individual's ability to safely operate key-locking devices.
- **viii.** The individual's ability to evacuate from the residence.

### Description of Violation

The assessment for resident #1, dated 9/17/2019, is blank in all areas under "Assisted Living Care Need and Degree" and "Behavioral or Cognitive Need and Degree." The assessment is also blank in the area of medication self-administration.

The assessment for resident #2, dated 9/18/2019, is blank in all areas under "Assisted Living Care Need and Degree" and "Behavioral or Cognitive Need and Degree." The assessment indicates that the resident is independently mobile, however, the resident was admitted to the SCU on 9/18/2019. Under supervision, the assessment indicates the resident requires no supervision and total supervision. The assessment is also blank in the area of medication self-administration.

The assessment for resident #4, dated 9/10/2019, is blank in all areas under "Assisted Living Care Need and Degree" and "Behavioral or Cognitive Need and Degree." The assessment is also blank in the area of medication administration and indicates that the resident has no vision needs; however, resident #4 requires eyeglasses.

The assessment for resident #5, dated 9/10/2019, is blank in all areas under "Assisted Living Care Need and Degree" and "Behavioral or Cognitive Need and Degree."

The assessment for resident #6, dated 9/21/2019, is blank in all areas under "Assisted Living Care Need and Degree" and "Behavioral or Cognitive Need and Degree." The assessment is also blank in the area of medication self-administration. Under supervision needs, the assessment indicates the resident requires no supervision in the home; however, the resident was admitted to the SCU on 9/21/2019.

### 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.)

At the time of survey, support plans were found to be incomplete with areas of inaccuracy. Surveyors on site very graciously educated our leadership team to the Departments expectations regarding support plan completion and specificity. All support plans were evaluated by Resident Service Director [redacted] RN and completed appropriately. [redacted] RN begins the preadmission portion of the support plan while [redacted] RN reviews support plan prior to move-in to ensure their appropriateness. [redacted] will be responsible to monitor, update, and review support plans after admission. Evaluations will be completed no less than quarterly to ensure ongoing accuracy. In the event there is a significant change, an assessment will be completed within 5 calendar days of the change as required by the Department.

## 224a5 Written initial assessment *(continued)*

**Legal Entity Representative**

Anne Giehl
Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19
Printed Name and Title Date

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

The above plan of correction is approved as of 12/31/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 224c8 Preliminary support plan - participants' signatures

### Requirements

2800.
224.c.8. Individuals who participate in the development of the preliminary support plan shall sign and date the preliminary support plan.

### Description of Violation

The following support plans are not signed by the residents and do not indicate if the resident was unable or refused to participate in the development of the plan or to sign the plan.

-Resident #1, dated 9/17/2019

-Resident #2, dated 9/18/2019

-Resident #5, dated 9/10/2019

-Resident #6, dated 9/21/2019

### 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.)

Preliminary support plans have always been developed with the participation of residents, guardian, and/or their physician. The facility was admittedly out of compliance with gathering the appropriate signatures to reflect this. Support plans have been reviewed with families and residents appropriately, and signatures have been obtained. Admission nurse Jane Rudy, RN has been working with families and residents to ensure pre-admission/admission accuracy of support plans. Resident Service Director Sharyce Greene, RN reviews admission paperwork to ensure compliance. A Nursing Office Manager, Tandra Jones has also been hired and will assist with auditing charts to ensure ongoing compliance with documentation. Regional Quality Assurance Director Jeff Santon, RN will also conduct quarterly and as needed audits to maintain ongoing compliance.

### Legal Entity Representative

| Signature | Printed Name and Title | Date |
|---|---|---|
| Anne Giehl | ANNE GIEHL, EXEC. DIRECTOR | 12/21/19 |

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

The above plan of correction is approved as of 12/31/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 226a Mobility – assessment

### Requirements

**2800.**
**226.a.** The resident shall be assessed for mobility needs as part of the resident's assessment.

### Description of Violation

The assessment for resident #4, dated 9/10/2019, indicates that the resident is independently mobile, however, resident #5 resides in the SCU and requires assistance with both transferring and ambulation.

The assessment for resident #5, dated 9/10/2019, indicates that the resident is independently mobile, however, resident #5 resides in the SCU and requires assistance with both transferring and ambulation.

The assessment for resident #6, dated 9/21/2019, indicates that the resident is independently mobile, however, resident #6 resides in the SCU and requires assistance with ambulating both short and long distances.

### 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.)

There was admittedly some lack of understanding regarding SCU residents and their mobility status. Surveyors graciously educated leadership that independent mobility includes the ability to transfer independently as well as ambulate without the need of cueing. Assessments were reviewed and updated accordingly following this education. Both [redacted] RN and [redacted] RN were educated and currently perform the residents assessments. Any future designees will be educated in understanding clearly the mobility status. Quarterly evaluations will be completed to ensure accuracy of support plans which will be updated accordingly. Regional Quality Assurance Director RN [redacted] or his designee will audit no less than monthly to ensure ongoing compliance.

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 231b Medical evaluation

### Requirements

2800.
231.b. Medical evaluation. A resident or potential resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission.

1. Documentation for a special care unit for residents with Alzheimer's disease or dementia must include the resident's diagnosis of Alzheimer's disease or dementia and the need for the resident to be served in a special care unit.
2. Documentation for a special care unit for INRBI must include the resident's or potential resident's diagnosis of brain injury and need for residential services to be provided in a special care unit for INRBI. The evaluation must include visual function, hearing, swallowing, mobility and hand function.

### Description of Violation

The medical evaluation for resident #2, completed on 9/6/2019, is blank in the areas of date of in-person evaluation, type of evaluation and immunization history. Resident #2 was admitted to the SCU on 9/18/2019.

The medical evaluation for resident #4, dated 7/12/2019, does not include a diagnosis of Alzheimer's disease or dementia. Resident #4 was admitted to the SCU on 9/10/2019.

The medical evaluation for resident #6, admitted to the SCU on 9/21/2019, was completed on 7/19/2019. Also, the medical evaluation does not indicate the resident has a diagnosis of Alzheimer's disease or dementia, and the need for resident #6 to be served in an SCU.

### 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.)

Resident 4's physician contacted and iphysician confirmed resident #4 has a diagnosis of dementia. - JRW 6/15/20

All medical evaluations are now evaluated by a dedicated pre-admission/admission nurse. Forms that are incomplete or missing information are returned to physician and full completion of the assessment is requested. Resident Service Director [redacted] RN or the appropriate designee reviews all admission paperwork prior to move-in to ensure paperwork is appropriate prior to move-in. A Nursing Office Manager, [redacted] has also been hired and will assist with auditing charts to ensure ongoing compliance with documentation. All SCU move-ins will be required to have the proper diagnosis moving forward. Residents without the proper diagnoses were either moved to Assisted Living after consultation with their physician, or the proper diagnosis has been obtained.

### Legal Entity Representative

| Signature | Printed Name and Title | Date |
|---|---|---|
| Anne Giehl | ANNE GIEHL, EXEC. DIRECTOR | 12/21/19 |

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

The above plan of correction is approved as of 6/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 231c1 Preadmit screening

### Requirements

**2800.**
**231.c.1.** Special care unit for residents with Alzheimer's disease or dementia.

i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

ii. A geriatric assessment team is a group of multidisciplinary specialists in the care of adults who are older that conducts a multidimensional evaluation of a resident and assists in developing a support plan by working with the resident's physician, designated person and the resident's family to coordinate the resident's care.

### Description of Violation

Cognitive preadmission screenings were not completed for the following residents of the SCU:

-Resident #2, admitted 9/18/2019

-Resident #4, admitted 9/10/2019

-Resident #6, admitted 9/21/2019

### 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.)

All residents in special care units now have the Departments cognitive preadmission screening form completed. Moving forward, all future SCU residents will have a cognitive preadmission screening completed and documented on the Departments form in collaboration with the residents physician prior to move-in. The Departments form is now included in the SCU preadmission packet as part of the necessary paperwork that must be completed prior to a residents move-in. [redacted] RN now performs preadmission assessments and is aware of the regulation. Any designee that may be necessary in the future will be educated of the requirement. Resident Service Director [redacted] RN will review all admission paperwork prior to residents move-in to ensure compliance. Quality Assurance Director RN, [redacted] or his designee will perform monthly chart audits to also ensure ongoing compliance as well.

### Legal Entity Representative

| Signature | Printed Name and Title | Date |
|---|---|---|
| Anne Giehl | ANNE GIEHL, EXEC. DIRECTOR | 12/21/19 |

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 231d No objection statement

### Requirements

2800.
**231.d.** Resident admission to special care unit. Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.

### Description of Violation

There is no documentation that the resident and the resident's designated person have agreed to admission into an SCU for the following residents:

-Resident #2, admitted 9/18/2019

-Resident #4, admitted 9/10/2019

-Resident #6, admitted 9/21/2019

### 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.)

The Administrator had obtained verbal agreement from the Resident's designated person/resident's family to transfer the resident to the SCU. The signed Acknowledgment of Addendum B Memory Care is modified to include documentation that the family is in agreement of the move to SCU
A designated staff person will review all documentaton for all new SCU residents at the time of admission to ensure documentation of agreement to reside in the SCU is in the resident record. - JRW 5/15/20

### Legal Entity Representative

Anne Giehl — Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19 — Printed Name and Title / Date

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented

☒ Not Implemented

## 236a Staff training

### Requirements

**2800.**
**236.a.** Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

### Description of Violation

The following staff persons, who work in the residence's SCU, have not received any Alzheimer's disease or dementia specific trainings:

-Staff person B, hired 8/19/2019

-Staff person D, hired 10/1/2019

-Staff person E, hired 9/18/2019

### 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.)

The Administrator and Business Office Director (BOD) have audited all employee files for compliance with 2800.236a. Additional training with documentation was provided to staff and the on-line training platform, Relias has been instituted for compliance with on-site RN/LPN dementia training provided individually to staff as needed. Likewise, Agency staff was given required dementia training or discontinued from service in the community.
he Human Resources Assistant will ensure that all required training is performed with supporting documentation placed into the employee file. The Business Office Director (BOD) will perform monthly for the completeness of the employee file and Quarterly Audits will be performed by the COO/designee for verification of compliance.

### Legal Entity Representative

Anne Giehl
Signature

ANNE GIEHL, EXEC. DIRECTOR 12/21/19
Printed Name and Title Date

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

The above plan of correction is approved as of 12/31/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented

☒ Not Implemented

## 251c Standardized forms

### Requirements

2800.
**251.c.** The residence shall use standardized forms to record information in the resident's record.

### Description of Violation

The medical evaluation for resident #6, dated 7/19/2019, was not completed on the required assisted living residence form; it was completed on the form for personal care homes.

### 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.)

Resident #6s medical evaluation was erroneously completed on the incorrect state form. Assisted Living and Personal Care Home folders with the correct paperwork are now prepared prior to assessment to help ensure that correct paperwork is used for assessments. Resident Service Director Sharyce Greene, RN or her appropriate designee will review all pre-admission paperwork prior to move-in to ensure compliance moving forward. A Nursing Office Manager, Tandra Jones has also been hired and will assist with auditing charts to ensure ongoing compliance with documentation.

### Legal Entity Representative

| Signature | Printed Name and Title | Date |
|---|---|---|
| Anne Giehl | ANNE GIEHL, EXEC. DIRECTOR | 12/21/19 |

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

The above plan of correction is approved as of 12/31/19 (Date)

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

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

RECEIVED
MARCH 26 2020
WEST REGION FIELD OFFICE
Human Services Licensing

# Violation Report

## Facility Information

**Name:** *Tapestry Senior Living Moon Township* **License Number:** *45009*
**Address:** *550 Cherrington Parkway, Coraopolis, PA 15108*
**County:** *ALLEGHENY* **Region:** *WESTERN*

## Administrator

**Name:** *Anne Giehl* **Phone:** *412-480-4904* **Email:** *anne.giehl@tapestrysenior.com*

## Legal Entity

**Name:** *Tapestry Companies, LLC*
**Address:** *2001 Killebrew Drive, Suite 100, Minneapolis, MN, 55425*

## Certificate(s) of Occupancy

**Type:** *I-1* **Date:** *07/29/2019* **Issued By:** *Moon Township*

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *100* **Waking Staff:** *75*

## Inspection

**Type:** *Full* **BHA Docket #:** **Notice:** *Unannounced*
**Reason:** *Renewal,Provisional,Incident,Monitoring*

## Inspection Dates and Department Representative

*01/02/2020 - On-Site: Josh Hoover, Barb Barone, Deb McConnell*

*01/03/2020 - On-Site: Josh Hoover, Barb Barone, Deb McConnell*

*01/15/2020 - On-Site: Josh Hoover, Barb Barone, Deb McConnell*

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *104* **Residents Served:** *60*

### Special Care Unit

**In Home:** *Yes* **Area:** *Memory Care* **Capacity:** *71* **Residents Served:** *27*

### Hospice

**Current Residents:** *2*

### Number of Residents Who:

**Receive Supplemental Security Income:** *0*
**Are 60 Years of Age or Older:** *60*
**Diagnosed with Mental Illness:** *1*
**Diagnosed with Intellectual Disability:** *0*
**Have Mobility Need:** *40*
**Have Physical Disability:** *0*

## 15a Resident abuse report

### Requirements

2800.

15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

### Description of Violation

On 10/11/2019. an allegation of sexual abuse involving resident #1 was reported to staff person A, the residence's Executive Director. This allegation was not reported to the local Area Agency on Aging. until 1/3/2020.

### 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.)

**The Executive Director apologizes for not reporting the allegation immediately to Area Agency on Aging at the time of the allegation. Law Enforcement was notified immediately on 10/11/19 to investigate the allegations. Police report #20191010M0028. An incident report was filed within 24 hours to the Bureau of Human Services Licensing. (see attached)**

**The Executive Director has be reeducated on the Older Adult Protective Services Act to ensure future compliance with mandatory reporting of older adults. This has been accomplished through Relias training and the Department of Aging's educational PowerPoint on OAPSA.**

### Legal Entity Representative

Anne Giehl
Signature

Digitally signed by Anne Giehl
Date: 2020.03.02 10:38:24 -05'00'

Anne Giehl, Executive Director
Printed Name and Title

3/2/2020
Date

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented
[ ] Not Implemented

## 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

Residents #2, #3, #4, #5 and #6 ceased to breathe in the residence on their respective dates of death. These incidents were not reported 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.)

There was a misinterpretation o the Regulatory Compliance Guide (RCG) which states, "an unexpected death of a resident." The residents listed all passed away while on hospice, they were expected deaths and therefore not reported. Your surveyor explained the misinterpretation and the Executive Director filed the required incident reports to correct the error.

The Executive Director or designee will now report all deaths as required by 2800.16 in the 24 hour period. The Business Office Director will verify timely compliance of this filing by adding it to her move out checklist.

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 10:39:13 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

☒ Implemented

☐ Not Implemented

## 17 Record confidentiality

### Requirements

**2800.**

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

### Description of Violation

On 1/2/2020, the following confidential resident records were unattended and accessible:

- At approximately 11:00a.m., numerous empty medication packages were on top of the treatment cart across from living unit #314, containing resident names, dates of birth, and medication orders for multiple residents, including residents #7 and #8.

- At approximately 2:00p.m., a narcotic count binder was on top of the medication cart near living unit #207, containing names, dates of birth, and physician orders for numerous residents, including residents #9 and #10.

- At approximately 2:15p.m., a narcotic count binder was on top of the medication cart at the nurse's station near living unit #232 that included names, dates of birth, and medication orders for numerous residents, including residents #11 and #12. Also, there was accessible and unattended confidential information of residents #12 and #13 on the desk at the nurse's station.

### 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.)

**HIPPA education was started immediately on 1/2/20 when surveyors brought this to the attention of leadership. Training and education provided was specific to narcotic count binder location, HIPPA compliance regarding medications, as well as resident information being left unattended at nursing stations. All narcotic binders were also marked with a bright yellow label reading "Do not leave on cart please lock up" as a reminder to staff that narcotic binders cannot be left unattended on the medication carts. Resident Services Director Sharyce Greene, RN and Assistant RSD Angela Simmons, RN and their designees will provide ongoing monitoring and re-education as needed to ensure ongoing compliance.**

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 10:41:15 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

The above plan of correction was approved by (Initials)

## 25b Contract signatures and renewal

### Requirements

2800.

**25b .** The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

### Description of Violation

The resident-residence contract for resident #15, dated 8/6/2019, is not signed by the resident.

The resident-residence contract for resident #16, dated 8/30/2019, is not signed by the resident.

### 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.)

**The Executive Director had the above mentioned residents sign their residency contracts as required by 2800.25b. (see attached)**

**The Business Office Director audited all resident contracts to ensure that they are signed by the resident and payor,...and cosigned by the resident's designated person if any, if the resident agrees. All contracts are in compliance as of this writing.**

**The Business Office Director or designee will use a resident file audit checklist to ensure all new resident contracts are executed properly moving forward.**

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 10:45:28 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented

☒ Not Implemented

## 41e Signed statement

### Requirements

2800.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

### Description of Violation

There is no signed statement of acknowledging receipt of a copy of residents' rights in the records of resident #15, admitted 8/25/2019, and resident #16, admitted on 10/21/2019.

### 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.)

**The Executive Director had the above mentioned residents sign their resident rights as required by 2800.41e. (see attached)**
**The Business Office Director audited all resident contracts to ensure that they are signed by the resident and payor,...and cosigned by the resident's designated person if any, if the resident agrees. All contracts are in compliance as of this writing.**
**The Business Office Director or designee will use a resident file audit checklist to ensure all new resident contracts are executed properly moving forward.**

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 10:45:48 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented
[ ] Not Implemented

## 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.

### Description of Violation

The following direct care staff persons did not receive training on the emergency medical plan:

- Staff person B, hired 8/5/2019
- Staff person C, hired 8/5/2019
- Staff person D, hired 9/30/2019
- Staff person E, hired 11/18/2019

### 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.)

**In January 2020, the on-line learning platform Relias was instituted at Tapestry Moon, LLC. to help consistently educate our staff in accordance to the requirements of 2600.65. The Emergency Medical Plan is part of Relias. It is assigned to all staff at the start of employment and audited, by the Business Office Director, within 40 hours of employment to ensure compliance. All staff was assigned emergency medical plan training in Relias and live in service training specific to our community. (Attached course description)**

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 10:46:20 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

[ ] Implemented
[X] 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

The following direct care staff persons have not received any dementia-specific training:

- Staff person B, hired 8/5/2019
- Staff person C, hired 8/5/2019
- Staff person D, hired 9/30/2019
- Staff person E, hired 11/18/2019

### 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.)

**In January 2020, the on-line learning platform Relias was instituted at Tapestry Moon, LLC. to help consistently educate our staff in accordance to the requirements of 2800. All staff was assigned training to cover the 4 hours of dementia specific training within 30 days of hire and/or 2 hours of annual dementia training. Compliance with this training is performed by the Business Office Director quarterly.**

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 10:46:39 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

- ☐ Implemented
- ☒ Not Implemented

## 81b Resident equip – good repair

### Requirements

2800.
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

On 1/2/2020, the enabler on resident #14's bed was not well-secured to the bed. There was a gap measuring approximately 4 inches between the enabler and the mattress, posing an entrapment hazard.

### 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.)

**The enabler was removed. A letter was sent to all the DME companies and families notifying them that enablers must be approved by Resident Services Director prior to install. An audit of all rooms was performed by the Resident Services Director to ensure no others were present.**

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:10:44 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

☒ Implemented
☐ Not Implemented

## 91 Telephone Numbers

### Requirements

2800.

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

### Description of Violation

On 1/2/2020, there were no emergency numbers posted on or nearby the following telephones with outside lines:

- Nurse's station near living unit #332
- Living unit #315, occupied by residents #14 and #18
- Nurse's station near living unit #307
- Nurse's station near living unit #239

### 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.)

**On 1/2/2020, Quality Assurance Director, Jeff Santon, posted emergency numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline at above noted nursing stations as acknowledged by surveyors. Likewise, Santon audited all nursing station phones for compliance of 2800.91. (see attached)**

**The Executive Director, posted required emergency numbers in living room of unit #315 and in all residents' private quarters near the thermostat as directed by Surveyor McConnell. (see attached)**

**A monthly audit of all phones is performed by Housekeeping Supervisor to ensure emergency numbers are not moved or misplaced from posted locations.**

### Legal Entity Representative

| | | | |
|---|---|---|---|
| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:11:09 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

X Implemented

☐ Not Implemented

The above plan of correction was approved by (Initials)

## 96b First aid kit- Location

**Requirements**

**2800.**
**96.b.** Staff persons shall know the location of the first aid kit.

**Description of Violation**

Numerous staff persons did not know the locations of any first aid kits when interviewed, including direct care staff persons F and G.

**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.)

**Staff was immediately re-educated to the location of the facilities first aid kits. Large red signs reading "FIRST AID KIT" were immediately placed on all cabinets containing kits. Resident Service Director Sharyce Greene, RN and her designees will ensure the continued education of staff as well as the implementation of signage that identifies the cabinets which contain first aid kits.**

**Legal Entity Representative**

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:11:32 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

X Implemented
☐ Not Implemented

## 103g Storing food

### Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

### Description of Violation

On 1/2/2020, at approximately 2:00p.m., there was an unsealed container of cheese squares in the refrigerator in the kitchenette of the 2nd floor SCU.

### 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.)

**Chef Frank, immediately disposed of the unsealed foods and had an immediate in service with all Dietary/Clinical Staff regarding the storing, labeling and dating of all foods in the walk in coolers and freezers. He is also monitoring it daily to ensure compliance. (Attach in-service)**

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:11:55 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

X Implemented
☐ Not Implemented

The above plan of correction was approved by (Initials)

## 132c Fire drill records

**Requirements**

2800.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

**Description of Violation**

The fire drill records for drills conducted on 10/24/2019, 10/31/2019, 11/1/2019, and 12/31/2019 do not include the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

**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.)

**As directed by surveyor, Executive Director, Anne Giehl printed off the suggested form from the DHS website which includes the date, time, the amount of time it to evacuate, # of residents in the home at the time of the drill, # residents evacuated, # of staff persons participating, problems encountered and whether the fire alarms or smoke detector was operative for fire drills. The required information is now kept on the form for compliance during all fire drills. (See form)**

**Legal Entity Representative**

| | | | |
|---|---|---|---|
| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:12:21 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

X Implemented

☐ Not Implemented

## 132d Evacuation

### Requirements

2800.

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 residence.

### Description of Violation

According to the fire safety inspection documentation dated 8/21/2019, the sole designated fire safe areas on floors 2, 3 and 4 are the enclosed elevator lobbies by elevator #5. Staff and resident interviews indicate that during fire drills conducted on 10/24/2019, 10/31/2019, 11/1/2019, and 12/31/2019, residents on the 2nd, 3rd, and 4th floors were not evacuated to the fire safe area. Residents were evacuated to the open-air areas in front of elevators #1, #2, #3, and #4.

### 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.)

The Fire Evacuation Plan addendum mentioned above, dated 8/21/19 (attached), states "Additionally, the elevator lobby areas on floors 1, 2, 3, and 4, meet the Standards for Chapter 2800 and the 5th floor meet the Standards 2600 as fire safe areas of the building for assembly."

We believe that our fire drill practice, as stated in the violation above, is in accordance with this statement from the Fire Chief of Moon Township, and that we are in compliance with the regulations. However, we are actively investigating additional areas of the building that could be converted to fire safe areas. We have engaged the services of an outside fire safety expert to provide us with guidance on identifying and/or creating these additional fire safe areas. We look to submit architectural plans incorporating these ideas/suggestions and submit them to Moon Township for their approval. Once approved, we will begin to execute the plan to add these additional fire safe areas to our current areas as noted in the addendum dated 8/21/19.

On 1/23/20, a fire drill was conducted and all resident were evacuated to a designated fire safe area. The administrator will ensure that all residents are evacuated to the designated fire safe areas for each fire drill. - JRW 5/15/20

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:13:25 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

## 162c Menus - posted

### Requirements

2800.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

### Description of Violation

On 1/2/2020 and 1/3/2020, weekly menus for the home were in a binder behind the reception desk. This is not a conspicuous and public place in the home.

### 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.)

**Chef Frank and/or designee have "Always available menus" on display on all the tables in all the dining venues at all times. In addition, the weekly specials menus are posted in a binder at the front desk also with the sign in/sign out guest log. While we maintain our menus are posted conspicuously, they are now broadcast on public TVs in areas throughout the building as well as in picture frames at our bar showing 2 weeks of advanced specials.**

**Chef Frank, changes the weekly specials menus on the tables, TVs and frames in the bar weekly for ongoing compliance. (See pictures)**

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:14:15 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

X 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 1/2/2019, there were numerous unlocked medications in the living unit of resident #18 and #14, including Hydrocortisone cream, Maximum Strength Mucinex DM, Acetaminophen, and a 5-day pill container filled with various unknown medications. Resident #18, who does not have a diagnosis of dementia, resides in the SCU in a living unit with resident #14, who has a diagnosis of dementia and is assessed as unable to self-administer medications. Also, resident #18 indicates that she does not keep medications in a locked area and does not lock the door when she leaves the unit.

**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.)

**Resident #18 was educated on the importance of locking up her medications. Resident was provided a lock box and verbalized an understanding of what was being asked of her. This residents medications have been found to be locked up appropriately on all subsequent checks. Resident Service Director [redacted], RN and her designees will continue to monitor this to ensure ongoing compliance.**

**Legal Entity Representative**

| | | | |
|---|---|---|---|
| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:14:40 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented
[ ] Not Implemented

The above plan of correction was approved by (Initials)

## 183e Storing Medications

### Requirements

2800.

**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

A bottle of Latanoprost .005% eye drops for resident #19 was dated as opened on 9/20/2019 and was on the medication cart. Manufacturer's instructions indicate the eye drops should be disposed of 6 weeks after opening. Staff interviews indicate that the expired medication was administered to the resident on 1/14/2020.

### 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.)

Education provided by Johnsons Pharmacy regarding the expiration and proper dating of medications. Pharmacy to provide quarterly cart audits moving forward. Resident Service Director Sharyce Greene, RN performed a medication audit on 1/27/20 to all carts to ensure there are no expired medications present for administration. [redacted] RN or her appropriate designee will perform monthly cart audits to ensure ongoing compliance.

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:21:24 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

[X] Implemented

[ ] Not Implemented

The above plan of correction was approved by (Initials)

## 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 #12 is ordered blood glucose monitoring four times daily with sliding scale insulin coverage before every meal. Discrepancies were on resident #12's medication administration record (MAR) and the glucometer readings are as follows:

| Date | Time | Glucometer reading | MAR |
|---|---|---|---|
| 1/11/2020 | 5:38p.m. | No reading present | 247 |
| 1/14/2020 | 4:15p.m. | No reading present | 322 |

### 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.)

Education provided to staff on 12/23/2019 that glucometers should not be shared among multiple residents. It is unclear if another glucometer was used to obtain the documented glucometer readings. Audits were performed on the other glucometers and there were not readings discovered on another glucometer that matched what was documented on the MAR. Staff member G was the documenting nurse on both occasions and could not provide an explanation for the discrepancy. Staff member G is an agency nurse and is no longer working shifts at Tapestry Moon. Resident Service Director [redacted], RN and/or her designee will perform random monthly audits on the glucometers to ensure they match what is documented.

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:22:24 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

- ☐ Implemented
- ☒ Not Implemented

The above plan of correction was approved by (Initials)

## 187d Follow prescriber's orders

### Requirements

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

### Description of Violation

Resident #11 is ordered Tramadol 50mg, take 1 four times a day. The resident did not receive the medication on 1/8/2020 at 8:00a.m. or 12:00p.m. as it was not available in the residence.

Resident #11 is ordered Advair 250/50 diskus, inhale 1 puff twice daily. The resident did not receive the medication on 1/9/2020 at 5:00p.m. or 1/12/2020 at 5:00p.m.

Resident #12 is ordered Lantus Solostar, inject 10 units twice a day; however, this medication was not administered on 1/12/2020 at 8:00p.m. or 1/13/2020 at 8:00a.m. as it was not available in the residence.

Resident #12 is ordered Novolog Flexpen with sliding scale coverage before all meals; however, this medication was not administered on 1/6/2020 at 4:00p.m. as it was not available in the residence.

Resident #19 is ordered Latanoprost .005% ophthalmic solution, instill 1 drop in both eyes at bed time; however, this medication was not administered on 1/5/2020.

### 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.)

The facility was admittedly having some communication issues with the pharmacy which was at times causing delays in the ordering of medications. Johnson's Pharmacy was having issues with accessing information through Eldermark, which is the EMAR system used at Tapestry. After a number of meetings with both groups, Johnson's Pharmacy was able to "download the RDU" and have an account set-up through Eldermark. Johnson's Pharmacy is now alerted in real time to any changes in orders and their QA Nurses can perform audits to ensure information is correct in both systems. This has resulted in orders being processed more timely.

Staff continues to be educated and re-educated on the significance of missed medications with disciplinary action when appropriate. Resident Service Director [redacted] RN and/or her designee perform daily audits for missed medication in real time. These audits will continue moving forward to ensure compliance. Quality Assurance Nurse [redacted] RN is currently performing EMAR audits no less than weekly.

### Legal Entity Representative

| | | | |
|---|---|---|---|
| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:23:04 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented
☒ Not Implemented

The above plan of correction was approved by (Initials)

## 203 Bedside rails

### Requirements

2800.

203.a. Bedside rails may not be used unless the resident can raise and lower the rails on his own. Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.

### Description of Violation

On 1/15/2020, there were full-length bed rails on both sides of resident #20's bed.

### 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.)

Tapestry would have never knowingly allowed this bed into the community. After investigation it was determined that this bed had just recently been provided to the resident from a home health company. Notifications were sent to our vendors on 1/27/2020 notifying them that we do not allow bed rails in our facility. We also immediately added a notification of no bed rails to our pre-admission paperwork for families as well. Staff has also been educated to immediately make leadership aware should they see any bed rails in the community.

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:38:12 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

X Implemented

☐ Not Implemented

## 231d No objection statement

### Requirements

2800.

231.d. Resident admission to special care unit. Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.

### Description of Violation

Numerous residents of the SCU do not have documentation that the resident and the resident's designated person/family have agreed to admission into an SCU, including the following:

- Resident #14, admitted to the SCU on 10/24/2019
- Resident #16, admitted to the SCU on 10/21/2019

### 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.)

Resident #14 is a resident of the SCU, he resides there with his wife who signed the resident contract for herself and her husband as his Power of Attorney. It is also signed by the resident's family, agreeing to the SCU. Resident #14 is advanced in his disease process and unable to sign the agreement; further his wife/POA and family did not want to cause distress with a formal agreement of admission into the SCU.
Resident #16 is a resident of the SCU, her daughter and Power of Attorney signed her residency contract agreeing to admission to the SCU. The resident was also able to sign the contract although her dementia does not allow her to understand what she consented to.

An audit of SCU resident contracts was performed by the Business Office Director to ensure compliance with 2800.231d. All SCU resident contracts are signed by a resident family member/POA. Resident contracts not signed by the resident living in the Special Care Unit have been corrected with a signature of acknowledgment. All future contracts for the SCU are signed by both the Alzheimer's/Dementia resident and their family acknowledging admission in the SCU.

A designated staff person will review all documentaton for all new SCU residents at the time of admission to ensure documentation of agreement to reside in the SCU is in the resident record. - JRW 5/12/20

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:39:53 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented
☒ Not Implemented

The above plan of correction was approved by (Initials)

## 233d Electronic/magnetic system

### Requirements

**2800.**
**233.d.** Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

### Description of Violation

On 1/2/2020, at approximately 12:12p.m., the door of the SCU was propped open and unattended near living unit #353. This door leads from the SCU to the regular unsecured area of the residence. Residents of the SCU require extensive supervision and to be in a secured unit, including resident #14.

### 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.)

**On 1/2/2020, the above mentioned door was immediately secured by Environmental Services Director. The workmen working on the locking system were educated on the need to keep the doors secured and/or supervised at all times.**

**The Environmental Services Director or designee will be present when work is being performed in the SCU to ensure a secure environment is maintained by workmen.**

### Legal Entity Representative

Anne Giehl
Signature

Digitally signed by Anne Giehl
Date: 2020.03.02 11:41:41 -05'00'

Anne Giehl, Executive Director
Printed Name and Title

3/2/2020
Date

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

The above plan of correction is approved as of 5/15/20 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/15/20 (Date)

X Implemented
☐ Not Implemented

## 234b Support plan - elements

### Requirements

**2800.**

**234.b.** Plan requirements.

1. The support plan and if applicable, the rehabilitation plan, must identify the resident's physical, medical, social, cognitive and safety needs.
2. The rehabilitation and support plan for residents of a special care unit for INRBI must identify the residents' emotional and behavioral needs.

### Description of Violation

The support plan for resident #14, dated 10/23/2019, does not include an adequate description of how the residence will meet the residents needs in numerous areas, including eating, drinking, transferring, bladder management, and bowel management. The description of service needs for these areas only indicates "needs assistance," or "moderate assistance." Also, the resident's use of an enabler on the bed is not addressed in the resident's support plan.

The support plan for resident #16, dated 10/21/2019, does not indicate the type and frequency of services provided by hospice. The resident began to receive hospice services on 12/12/2019.

### 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.)

**Resident Service Director [redacted] RN was present with surveyors when educated that the ASP needs more specificity regarding resident care. All ASPs have been reviewed and updated accordingly. An assistant RSD [redacted] RN has been added to the team and will assist [redacted] in keeping ASP's updated appropriately on a daily basis. Quarterly evaluations and reviews have been instituted for every resident as a safeguard to ensure that the services being provided are reflected on the residents support plan.**

### Legal Entity Representative

| | | | |
|---|---|---|---|
| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:43:57 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

- [X] Implemented
- [ ] Not Implemented

The above plan of correction was approved by (Initials)

## 236a Staff training

### Requirements

2800.

236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

### Description of Violation

The following direct care staff persons who work in the residence's SCU have not received any dementia-specific training:

- Staff person B, hired 8/5/2019
- Staff person C, hired 8/5/2019
- Staff person D, hired 9/30/2019
- Staff person E, hired 11/18/2019

### 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.)

**In January 2020, the on-line learning platform Relias was instituted at Tapestry Moon, LLC. to help consistently educate our staff in accordance to the requirements of 2800. All staff was assigned training to cover the 4 hours of dementia specific training within 30 days of hire and/or 2 hours of annual dementia training. Compliance with this training is performed by the Business Office Director quarterly.**

### Legal Entity Representative

| Anne Giehl | Digitally signed by Anne Giehl Date: 2020.03.02 11:45:02 -05'00' | Anne Giehl, Executive Director | 3/2/2020 |
|---|---|---|---|
| Signature | | Printed Name and Title | Date |

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

The above plan of correction is approved as of 5/15/20 (Date)

Plan of correction implementation status as of 5/15/20 (Date)

☐ Implemented
☒ Not Implemented

The above plan of correction was approved by (Initials)