Department of Human Services
Bureau of Human Service Licensing

May 14, 2021

[redacted], PRESIDENT
TAPESTRY MOON LLC
2001 KILLEBREW DRIVE, SUITE 100
BLOOMINGTON, MN 55425

RE: TAPESTRY SENIOR LIVING MOON TOWNSHIP
550 CHERRINGTON PARKWAY
CORAOPOLIS, PA, 15108
LICENSE/COC#: 45009

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 11/09/2020, 11/10/2020, 02/08/2021, 02/09/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Suzy Quinn

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *TAPESTRY SENIOR LIVING MOON TOWNSHIP* **License #:** *45009* **License Expiration Date:** *02/18/2021*
Address: *550 CHERRINGTON PARKWAY, CORAOPOLIS, PA 15108*
County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: [redacted] **Phone:** *4125079999* **Email:** [redacted]

Legal Entity

Name: *TAPESTRY MOON LLC*
Address: *2001 KILLEBREW DRIVE, SUITE 100, BLOOMINGTON, MN, 55425*
Phone: *4125079999* **Email:** [redacted]

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:** *137* **Waking Staff:** *103*

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Provisional* **Exit Conference Date:** *02/09/2021*

Inspection Dates and Department Representative

11/09/2020 - On-Site: [redacted]
11/10/2020 - On-Site: [redacted]
02/08/2021 - On-Site: [redacted]
02/09/2021 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served:** *72*

Special Care Unit

In Home: *Yes* **Area:** *Floors 1-2-3-4 MC* **Capacity:** *71* **Residents Served:** *44*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *72*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *65* **Have Physical Disability:** *0*

Inspections / Reviews

11/09/2020 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/10/2021*

4/16/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/22/2021*

5/14/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/22/2021*

17 Record confidentiality

1. 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 Repeat Violation

On 11/9/20, resident #1"s medication orders were visible on the screen of an unlocked, unattended and accessible laptop at the 3rd floor south secured care unit (SCU) nurse station.

On 11/9/20, a 24 hour charting report listing names of residents on the 3rd floor SCU and Assisted Living (AL) unit, to include resident #3, was unlocked, unattended and accessible at the 3rd floor north SCU nurse station.

On 11/9/20, a 24 hour charting report listing names of all residents, to include residents #1, #2, #3 and #4, was unlocked, unattended and accessible at the 3rd floor north AL nurses station.

On 11/9/20, a white binder labeled "MC3 A&B" containing resident information for all 3rd floor AL residents, to include resident #3, was unlocked, unattended and accessible at the 3rd floor north AL nurses station.

Repeat Violation: 01/02/2020 et al

Plan of Correction **Accept**

Resident's medication orders, 24 hour charting report and white binder labeled "MC3 A&B" were immediately secured in a locked cabinet at the nursing station on 11-9-2020. Signs were posted at each nursing station and nurses cart as a continuous reminder to protect the confidentiality of a resident's information. Even though HIPPA training is provided on hire and annually, an additional training is scheduled for all staff on May 6, 2021 regarding HIPPA compliance, confidentiality of resident's records and information and charting report to all staff. This education will be repeated quarterly x 2 quarters and then annually thereafter. All new hires will also receive this education. RSD or designee will monitor entire building daily to ensure compliance.

Completion Date: *05/26/2021*

42s Privacy - self/possessions

1. Requirements

2800.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 11/9/2020 at 10:05 am, an Amazon Echo labeled Tapestry Echo-1 was being used in the Allegheny Room with 8 residents seated in the area; however, this device has the capability of audio monitoring.

On 11/9/2020 at 10:39 am, an Amazon Echo labeled Tapestry Echo-2 was being used in the Parkside Grill with 1 resident seated in the area; however, this device has the capability of audio monitoring.

42s Privacy - self/possessions *(continued)*

Plan of Correction **Accept**

The audio monitoring device on the Amazon Echo's were turned off and were not being used in areas where bathing, dressing, changing and medical procedures were taking place. They were located in the dining areas to provide mood music for the residents. However, on 11-9-2020, the Amazon Echo's were removed from the area and replaced with CD players to continue to provide mood music for the residents. An in-service will be provided to all programming staff on May 6, 2021 regarding the resident's privacy. This education will also be given to any new programming staff. Programming Director or designee will monitor common areas daily to ensure compliance with regulation.

Completion Date: *05/26/2021*

2. Requirements

2800.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home requires all residents to use the home's Emergency Communication System (ECS) and provides residents with wristlets/pendants which are connected to the home's Ensure 360 Silversphere Companion One System. This system captures and analyzes thousands of data points from each resident daily and provides digital services including near real time location tracking, geofencing technology that alerts staff when a resident steps into or out of a defined parameter, forced egress notifications, tracking frequency of restroom habits and general activity, contact tracing and medical history, and includes a web based reporting system that allows management to review information from any location. However, the home has no written procedures regarding the digital services of the ECS system on obtaining written consent or allowing the resident to discontinue usage at any time, nor are there written procedures to ensure resident privacy/confidentiality will be maintained.

42s Privacy - self/possessions *(continued)*

Plan of Correction **Accept**

A policy was developed with regards to obtaining written consent and allowing the resident to discontinue usage at any time. It also includes information on how privacy/confidentiality will be maintained. Under Exhibit 1, item 2 of the contract, the Emergency Call System is addressed and clearly states that the resident has agreed to receive an Emergency Call System Pendant. A letter was sent on 2/5/2021 to all residents/responsible parties indicating this new policy. They were asked to accept or decline the pendant/wrist bracelet and to mark the consent or decline box, sign the form and return to the ED. In addition, by 4/30/2021, all residents/responsible parties will be sent a 30 day written notice explaining the changes to exhibit 1, item 2 and a signature request to indicate receipt of and agreement with the change. We have created a log that will identify submission of the signature page, which will then be placed in their admission file. The policy and consent/decline letter is included in our Admission packet as an addendum. This is now reviewed and signed upon admission. ED or designee will audit all new admission files within 5 days of admission for compliance with our policy. All residents/responsible parties were given a copy of the policy and the consent/decline form. If they decline the pendant/wrist bracelet, a Negotiated Risk Agreement will be completed within 5 days of receipt and signed by the Resident/Responsible Party, RSD and ED. If they decline, the RSD and ED or designees will meet with the resident/responsible family to coordinate an alternate plan. If a resident/responsible party declines to accept the ECS, the declination and the alternate plan will be entered into the resident health file and onto the employee's assignment/service plan. One component of the negotiated risk agreement will always be to include two (2) hour rounds (Wellness Checks) or more frequent rounds based on the resident's individual needs. During sleeping hours and so we do not disturb the resident's sleeping patterns, these rounds will be conducted by using a flashlight and staff will look for the rise and fall of the resident's chest. Another component will be to encourage the resident during scheduled activities to attend such activity at least 1 time per day; Encourage the resident to attend meals at least 1 time per day. These components will be placed on the resident's service plan. The consent/decline Negotiated Risk Agreements will be placed in the resident's file and a copy will be kept in a separate office in the clinical office. The ASP will be updated with the new information and alternate approach. An interview will conducted with all resident's between April 22, 2021 and April 30, 2021 to ensure their knowledge of the pendant's use. This will also be done at monthly Resident Council meetings and when each resident receives their quarterly assessment. On a quarterly basis or if there is a significant change, we will approach the resident/responsible party to see if they have changed their preference to have or not have the pendant. An in-service on what constitutes a significant change will be given to all staff, beginning on May 6, 2021 and continue every shift thru May 16, 2021. It will also be added to all new hire's orientation. A new policy will be completed to include all changes and mailed to residents/responsible parties with a signature page of acceptance by April 30, 2021.

For a clarification to the Emergency Call System's capabilities, our current Emergency Call System device does not collect or store a resident's private information. We use the Silversphere Companion One Equipment versus the Ensure360 Emergency Call System. Tapestry Moon is not tracking, NOR, is the Silversphere system tracking any resident private information. We reached out to Silversphere for clarification and they sent us the following response: "We have included all of the PDF documentation for all of the equipment onsite at Tapestry Moon Township that indicates it is only Silversphere Companion One Equipment. It has been brought to our attention that there is some confusion about the difference between a Companion One Emergency Call System and the new Ensure360 Emergency Call System. The community at Moon does not have the new Ensure360 Emergency Call System installed. They currently have the Companion One System that was installed in May of 2019. The Companion One System does not gather personal information or client data. The Silversphere Companion One System does not include Real Time Location Services, while the new Ensure360 System (just launched this year) does. The emergency calls are only displayed as Approximate locations and does not display any medical or personal information about the residents when an alarm is activated." We also reached out to Corporate IT Director and he sent us the following response: "Our policy has long been that PHI would not be stored on computers or Tapestry

Servers. We have controls in place on the internal systems such as the following: (1) Computer lock screens (2) Encrypted hard drives (3) Encrypted emailing (4) Encrypted data storage and (5) Antivirus. We are going to be rolling out very soon 24/7 SOC monitoring and additional layered security."

The ECD's will be inspected monthly by the ESD or designee to ensure they are functioning properly and to ensure programming technology is compliant with privacy requirements in accordance with $2600.42(s). An in-service was given to all staff on 2-4-2021 and will be given again on May 6, 2021 and quarterly thereafter.

84 Heat Sources

1. Requirements

2800.

84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120°F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

Description of Violation

On 11/9/20 at 11:23 am, the temperature of the metal food warming unit in the 2nd floor south SCU kitchen was 167 degrees Fahrenheit. The unit was unattended and accessible on a counter top next to the living/dining area where 7 unattended residents were seated. There were no protective guards in place to prevent residents from coming in contact with the food warming unit.

On 11/9/20 at 11:32 am, the temperature of the metal food warming unit in the 2nd floor north SCU kitchen was 129 degrees Fahrenheit. The unit was unattended and accessible on a counter top next to the living/dining area where 3 unattended residents were seated. There were no protective guards in place to prevent residents from coming in contact with the food warming unit.

Plan of Correction **Accept**

All metal food warming units were removed from the SCU on 11/9/2020. The meals are currently being transported via hot boxes. All meals are then removed from the hot boxes and presented to the residents. While on the SCU, the hot boxes will be pushed into the kitchen area out of the resident's reach, never left unattended and will be monitored by staff to ensure residents do not come into contact with them. The hot boxes are not used in any other area of the building. An in-service will be given on May 6, 2021 to all staff regarding leaving unattended hot items in a resident setting. Memory Care Coordinator or designee will monitor per shift on each SCU.

Completion Date: *05/26/2021*

85a Sanitary conditions

1. Requirements

2800.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/9/2020 at 10:11 am, there was large amount of used cooking grease on top of the cooking oil box.

On 11/9/2020 at 10:13 am, there were 12 cigarette butts on the ground outside of the kitchen delivery entrance.

Plan of Correction **Accept**

The cooking oil box was immediately cleaned on 11/9/2020. The cigarette butts were immediately picked up on 11/9/2020 and disposed of. Signs were posted on 4-24-2021, regarding "This is a non-smoking Campus and no smoking is permitted on campus". An in-service was given to all the staff on 3-4-2021, 4-1-2021, and will be given again on May 6, 2021 and monthly thereafter at general staff meetings regarding maintaining cleanliness and sanitary conditions. A letter was sent to all Staff on 4-20-2021, to remind them that we are a non-smoking campus and of their responsibility to adhere to this policy. ESD or designee will monitor both these areas daily to ensure compliance. This responsibility will be placed in the TELS work order system.

Completion Date: *05/26/2021*

85d Trash cans – kitchen/bath

1. Requirements

85d Trash cans – kitchen/bath *(continued)*

2800.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 11/9/20 at 11:24 am, an uncovered ½ full trash can was in the 2nd floor south SCU kitchen. The area was unattended.

On 11/9/20 at 11:34 am, an uncovered ¾ full trash can was in the 2nd floor north SCU kitchen. The area was unattended.

Plan of Correction **Accept**

Trash cans were emptied. Additional trash can lids were purchased and placed where needed. An in-service was given to all staff on 2-3-21, 3-5-21 and 4-1-21 and will be given again in May to ensure compliance. The Environmental Services Director or designee will monitor this on a weekly basis to ensure compliance. The weekly monitoring schedule was placed in TELS work order system. ED or designee will monitor on a quarterly basis to ensure compliance.

Completion Date: *05/21/2021*

85e Trash outside

1. **Requirements**

2800.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 11/9/20 at 10:27 am, a trash can with a top opening of 4"x4" was uncovered and 1/4 full of trash, near the front porch entrance.

Plan of Correction **Accept**

Trash can was immediately covered. Additional trash can lids were purchased and placed where needed. An in-service was given to all staff on 2-3-21, 3-5-21 and 4-1-21 and will be given again in May to ensure compliance. The Environmental Services Director or designee will monitor this on a weekly basis to ensure compliance. The weekly monitoring schedule was placed in TELS work order system. ED or designee will monitor on a quarterly basis to ensure compliance.

Completion Date: *05/21/2021*

93a Handrail

1. **Requirements**

2800.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On 11/9/20 at 10:30 am, there was no handrail in place for 3 steps leading down from the lower landing to the walkway on the Stair B exit porch.

93a Handrail *(continued)*

Plan of Correction **Accept**

The Environmental Services Department purchased necessary supplies and built a handrail for the steps leading down/up from the lower landing to the walkway on the Stair B exit porch. This was installed on March 10, 2021. All staff will be in-serviced on proper egress on May 6, 2021. ESD or designee will monitor all ramps, interior stairways and outside steps on a monthly basis to ensure railing are safe and functional. This monthly audit will be placed in our TELS work order system.

Completion Date: *05/06/2021*

103g Storing food

1. **Requirements**

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

Description of Repeat Violation

On 11/9/2020 at 10:44 am, 4 metal containers of wedding soup were uncovered in the walk in freezer.

On 11/9/2020 at 10:45 am, an unsealed bag of chicken tenders was in the walk in freezer.

Repeat Violation: 01/02/2020 et al

Plan of Correction **Accept**

Both items noted were immediately corrected. An in-service was given for all dietary staff on 11/6/2020, 3-5-2021 and 4-1-2021 and will be given again in May. A STOP sign is placed on the walk-in freezer doors to ensure that all contents of the freezer are covered, labeled and dated with entry and exit date. The Dietary Director or designee will monitor this daily to ensure compliance. ED will also monitor weekly to ensure compliance.

Completion Date: *05/07/2021*

105g Dryer lint removal

1. **Requirements**

2800.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 11/9/20 at 11:12 am, there was an approximate 3/4" accumulation of lint in the lint traps of the 5th and 6th dryers from the door, in the 2nd floor AL common laundry. There were no clothes in the dryer at the time.

Plan of Correction **Accept**

The 2nd floor AL common laundry had just been used to dry a load of resident clothing. The lint trap was immediately cleaned on 11-9-2020. An in-service was given to all staff on 4-1-2021 and will be given again on May 6 , 2021 and monthly thereafter at General Staff meetings. A sign was posted at the dryer on 4-21-2021 requesting users to "Please empty the lint trap after each use". This request will be mentioned at each monthly Resident Council meeting. Daily checking of the dryer lint traps will be added to housekeeping responsibilities check list. This responsibility will be added to the TELS work system program.

Completion Date: *05/06/2021*

141a Medical evaluation

1. 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:

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.

Description of Repeat Violation

Resident #5's Assisted Living Medical Evaluation form, dated 3/4/20, does not indicate the year [redacted] TB skin test was performed, nor does it indicate the medical professional's license number.

Repeat Violation: 10/04/2019 et al

Plan of Correction **Accept**

The TB dates and the Medical Professional's license number for Resident #5's AL Medical Evaluation form was verified and corrected by the ARSD, who called the physician's office on 4-20-2021 and the needed information was entered as a late entry onto the Assisted Living Medical Evaluation form. RSD audited all TB's from 4-1-21 thru 4/25/21 to ensure compliance and has created a spreadsheet to conduct this audit and ensure all requirements of this regulation are met. Professional Licensed clinical staff were given an in-service regarding this regulation on 1-29-21, and this will be repeated on May 6, 2021 and every shift thru May 16, 2021. RSD or designee will review every initial medical evaluation prior to admission or on the day of admission to ensure compliance. In addition, RSD or designee will monitor all new admissions monthly.

Completion Date: *05/26/2021*

144b Smoking – Home Rules

1. Requirements

2800.

144.b. The residence rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The residence does not permit smoking on the campus; however, on 11/9/20 cigarette butts were observed in the following locations:

** 12 cigarette butts were on the ground outside of the kitchen delivery entrance*

** A food can ½ full of cigarette butts was near the covered trash compactor area*

** 2 food cans full of cigarette butts were outside of the emergency responders entrance/exit door*

144b Smoking – Home Rules *(continued)*

Plan of Correction **Accept**

The cigarette butts and food cans full of cigarette butts were immediately picked up and disposed of on 11-9-2020. Signs were posted on 4-24-2021, regarding "This is a non-smoking Campus and no smoking is permitted on campus". An in-service was given to all staff on 3-4-2021, 4-1-2021 and will be given again on May 6, 2021 and monthly thereafter at General Staff meetings, regarding maintaining cleanliness and sanitary conditions. A letter was sent to all Staff on 4-20-2021, to remind them that we are a non-smoking campus and of their responsibility to adhere to this policy. ESD or designee will monitor these areas per shift to ensure compliance. This responsibility will be placed in TELS work order system.

Completion Date: *05/26/2021*

183b Medications and syringes locked

1. **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 Repeat Violation

On 11/9/20 at 1:39 pm, 2 unlabeled blister packs of Mucinex were unlocked, unattended, and accessible on the desk in the 3rd floor south SCU nurse's station.

On 11/9/2020 at 11:40 am, there was a 1.76 oz. jar of Vick's Vapor Rub that was ½ full, unlocked, in resident #6's bedroom #[redacted].

Repeat Violation: 01/02/2020 et al

Plan of Correction **Accept**

The 2 unlabeled blister packs of Mucinex were immediately secured in the medication cart on 11-9-2020.. The jar of Vick's Vapor Rub was removed from the resident's room. on 11-9-2020. A sweep of all nurses stations and resident rooms - with the permission of the resident/responsible party - was completed to ensure compliance with regulation. No other items were found. Families were provided a letter regarding what they can not bring into the building, such as over the counter medications, etc. An in-service was given on 1-29-2021 thru 1-31-2021, to all staff regarding the proper storing of all medications and over the counter medications/creams/rubs and privacy regarding resident medications and information and will be repeated on May 6, 2021, and every shift thru 5-256-2021 to ensure 100% staff participation. In all areas of the home, the Supervisor/MCC/LPN will check daily, on all shifts, for all prescription medications and over the counter medications/creams/rubs, etc. to ensure compliance. Also, the RSD or designee will conduct weekly audits for one quarter and then monthly checks thereafter in all areas of home to ensure compliance.

Completion Date: *05/26/2021*

183d Current medications

1. **Requirements**

2800.

183d Current medications *(continued)*

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

Description of Violation

On 11/10/20, 0.25mg Sertraline, prescribed for resident #4, was in the residence's medication cart; however, the medication was discontinued on 10/29/20.

On 11/10/20, Venlafaxine 150 mg ER capsules, prescribed for resident #7, was in the residence's medication cart; however, the medication was discontinued on 8/15/20.

On 11/10/20, Doxycycline Hyclate 100 mg, prescribed for resident #8, was in the residence's medication cart; however, the medication was discontinued on 11/9/20.

Plan of Correction **Accept**

The Sertraline, Venlafaxine and Doxycycline Hyclate medications were immediately removed from the medication cart and destroyed on 11-10-2020. An audit was conducted on November 11, 2020 and again on May 1 thru May 16 by the RSD or designee to ensure compliance for all other residents. An in-service will be given to all Licensed clinical staff regarding discontinued medications on May 6, 2021 and will continue on every shift thru May 16, 2021 to ensure 100% participation. The Nursing Supervisor on the 10p - 6a shift will monitor/clean medication carts weekly as part of her job responsibilities. RSD or designee will conduct audits of the carts weekly for one quarter and then monthly to ensure compliance. [redacted] *Pharmacy will conduct monthly audits on all carts and send report for follow-up by ED, RSD or designee.*

Completion Date: *05/26/2021*

184a Labeling

1. Requirements

2800.

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

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 Repeat Violation

On 11/10/20, the label on the brown plastic bag containing 8 syringes of resident #6's Morphine Sulfate did not include the following:

** The date the prescription was issued*

** The prescribed dosage and instructions for administration*

** The name and title of the prescriber*

On 11/10/20, the label on resident #7's Olanzapine 5mg contained a hand written quantity change from 30 to 60.

Repeat Violation: 10/4/19 et al

184a Labeling *(continued)*

Plan of Correction **Accept**

[redacted] *pharmacy was notified and the labeling was corrected on 11-11-2020. An audit was conducted on 11-12-2020 and May 1, 2021 thru May 16, 2021, for all remaining medications to ensure compliance. A refresher in-service will be given to all Licensed Clinical Staff on medication administration, labeling, the requirements for accepting medications from the Pharmacy and verifying medications with physician orders on May 6, 2021 and continuing every shift thru May 16, 2021, to ensure 100% participation. This in-service will be conducted every 2 years. RSD has created a spreadsheet to track all physician orders so that we remain in compliance. RSD or designee will conduct weekly audits for two quarters and then monthly thereafter to ensure 100% compliance.*

Completion Date: *05/26/2021*

187a Medication record

1. Requirements

2800.

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

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #7 is prescribed Divalproex 125mg - take 2 capsules by mouth twice a day. However, on 11/10/20, [redacted] November 2020 medication administration record did not indicate the diagnosis or purpose for the medication.

Plan of Correction **Accept**

Resident's diagnosis was updated on 11-12-2020, for the Divalproex medication. A refresher in-service will be presented on every shift beginning on May 6, 2021 thru May 16, 2021 for all Licensed Clinical Staff regarding all requirements of the medication administration record and physician orders. RSD has developed a spreadsheet for Physician Orders and will utilize it to ensure compliance. An audit to ensure every medication has an appropriate diagnosis will be conducted every shift on May 1, 2021 thru May 16,2021. Nursing Supervisor/RN/LPN will audit all MAR's and Medication Carts weekly to ensure compliance. Pharmacy will conduct monthly cart audits. RSD will conduct quarterly audits on MAR's and Medication Carts.

Completion Date: *05/26/2021*

223a Description of service

1. Requirements

2800.

223.a. The residence shall have a current written description of services and activities that the home provides including the following:

1. The scope and general description of the services and activities that the residence provides.
2. The criteria for admission and discharge.
3. Specific services that the residence does not provide, but will arrange or coordinate.

223a Description of service *(continued)*

Description of Violation

The home's written description of services and activities do not include the mandated usage of the ECS system, obtaining written consent from the resident for use of the ECS system, allowing the resident to discontinue usage at any time, procedures for lost or replacement wristlet/pendant, battery checks of the devices, who will have access to and be responsible for the system, how daily staffing assignments will work within the ECS system, and how resident privacy/confidentiality will be maintained.

223a Description of service *(continued)*

Plan of Correction **Accept**

A policy was developed with regards to obtaining written consent and allowing the resident to discontinue usage at any time. It also includes information on how privacy/confidentiality will be maintained. Under Exhibit 1, item 2 of the contract, the Emergency Call System is addressed and clearly states that the resident has agreed to receive an Emergency Call System Pendant. A letter was sent on 2/5/2021 to all residents/responsible parties indicating this new policy. They were asked to accept or decline the pendant/wrist bracelet and to mark the consent or decline box, sign the form and return to the ED. In addition, by 4/26/2021, all residents/responsible parties will be sent the exhibit 1, item 2 of the contract, which a signature request to indicate that they received exhibit 1, item 2 and that they are in agreement with the change. We have created a log that will identify submission of the signature page, which will then be placed in their admission file. The policy and consent/decline letter is included in our Admission packet as an addendum. This is now reviewed and signed upon admission. ED or designee will audit all new admission files within 5 days of admission for compliance with our policy. All residents/responsible parties were given a copy of the policy and the consent/decline form. If they decline the pendant/wrist bracelet, the RSD, ED or designees will meet with the resident/responsible party to coordinate an alternate plan. A Negotiated Risk Agreement will be completed within 5 days of receipt and signed by the Resident/Responsible Party, RSD and ED. If a resident/responsible party declines to accept the ECS, the declination and the alternate plan will be entered into the resident health file and onto the employee's assignment/service plan. One component of the negotiated risk agreement will always be to include two (2) hour rounds (Wellness Checks) or more frequent rounds based on the resident's individual needs. During sleeping hours and so we do not disturb the resident's sleeping patterns, these rounds will be conducted by using a flashlight and staff will look for the rise and fall of the resident's chest. Another component will be to encourage the resident during scheduled activities to attend such activity at least 1 time per day; Encourage the resident to attend meals at least 1 time per day. These components will be placed on the resident's service plan. The consent/decline Negotiated Risk Agreements will be placed in the resident's file and a copy will be kept in a separate office in the clinical office. The ASP will be updated with the new information and alternate approach. Within 5 days of receipt, the "Emergency Communications Devices Policy and Procedures and Negotiated Risk Agreement shall be updated to include alternate measures the home will provide to a resident if a resident does not wish to participate in the ECD system. Documentation will be kept. Also within 5 days of receipt, the revised "Emergency Communications Devises Policy and Procedures" shall be added to the home's description of services. An interview will conducted with all resident's between April 22, 2021 and April 30, 2021 to ensure their knowledge of the pendant's use. This will also be done at monthly Resident Council meetings and when each resident receives their quarterly assessment. On a quarterly basis or if there is a significant change, we will approach the resident/responsible party to see if they have changed their preference to have or not have the pendant. An in-service on what constitutes a significant change will be given to all staff, beginning on May 6, 2021 and continue every shift thru May 16, 2021. It will also be added to all new hire's orientation. A new policy will be completed to include all changes and mailed to residents/responsible parties with a signature page of acceptance by April 30, 2021.

For a clarification to the Emergency Call System's capabilities, our current Emergency Call System device does not collect or store a resident's private information. We use the Silversphere Companion One Equipment versus the Ensure360 Emergency Call System. Tapestry Moon is not tracking, NOR, is the Silversphere system tracking any resident private information. We reached out to the company for clarification and they sent us the following response: "We have included all of the PDF documentation for all of the equipment onsite at Tapestry Moon Township that indicates it is only Silversphere Companion One Equipment. It has been brought to our attention that there is some confusion about the difference between a Companion One Emergency Call System and the new Ensure360 Emergency Call System. The community at Moon does not have the new Ensure360 Emergency Call System installed. They currently have the Companion One System that was installed in May of 2019. The Companion One System does not gather personal information or client data. The Silversphere Companion One System does not include Real Time Location Services, while the new Ensure360 System (just launched this year) does. The emergency calls are only displayed as Approximate locations and does not display any medical or personal information about

the residents when an alarm is activated." We also reached out to Corporate IT Director and he sent us the following response: "Our policy has long been that PHI would not be stored on computers or Tapestry Servers. We have controls in place on the internal systems such as the following: (1) Computer lock screens (2) Encrypted hard drives (3) Encrypted emailing (4) Encrypted data storage and (5) Antivirus. We are going to be rolling out very soon 24/7 SOC monitoring and additional layered security."

The ECD's will be inspected monthly by the ESD or designee to ensure they are functioning properly and to ensure programming technology is compliant with privacy requirements in accordance with $2600.42(s). An in-service was given to all staff on 2-4-2021 and will be given again on May 6, 2021 and quarterly thereafter.

Completion Date: *05/26/2021*

225a1 Assessment – annually

1. Requirements

2800.

225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident #3's most recent assessment was completed on 10/9/20; however, [redacted] previous assessment was completed on 9/19/19.

Plan of Correction **Accept**

An audit was completed on April 20, 2021 on all assessments to ensure compliance. An in-service will be given on May 6, 2021 and will continue for all shifts thru May 16, 2021, to all Licensed Clinical Staff regarding the requirements of 2800.225.a.1. The RSD has created a spreadsheet to track assessment dates. RSD or designee will conduct weekly audits for 2 quarters and then monthly to ensure compliance.

Completion Date: *05/26/2021*

225b Assessment content

1. Requirements

2800.

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

5. The resident's need for supplemental health care services.

Description of Violation

Resident #2's assessment, dated 7/16/20, does not include home health care services that began on 8/20/20 for a foot wound.

Plan of Correction **Accept**

New ASP was completed for Resident #2 on February 10, 2021. An audit will be performed on all assessments to ensure compliance with added services, such as home health, hospice, significant changes, etc. on April 28, 2021 thru May 10, 2021. An in-service will be conducted on May 6, 2021 and on every shift thru May 16, 2021 to ensure 100% participation, to review this regulation and the requirements of the resident's need for supplemental services, in relationship with the assessments. RSD or designee will audit residents weekly for 2 quarters and then monthly to ensure compliance. Any changes identified shall e documented on the resident assessment with support plan revisions within 24 hours .

Completion Date: *05/26/2021*

231c1 Preadmit screening

1. Requirements

2800.

231.c.1.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.

Description of Repeat Violation

Resident #4 was admitted to the SCU on [redacted]; however, [redacted] written cognitive preadmission screening is undated.

Repeat Violation: 10/04/2019 et al

231c1 Preadmit screening *(continued)*

Plan of Correction **Accept**

Resident #4, has passed away, but placement was appropriate as related to additional assessments. On May 1, 2021 thru May 10, 2021, an audit will be completed for all residents admitted to the SCU for both having appropriate screens and dating of cognitive preadmission screenings. An in-service was conducted for the Licensed Clinical Staff regarding the requirements of the cognitive preadmission screening form on 1/29/2021 and again on May 6, 2021 and on all shifts thru May 16, 2021. RSD or designee will review all new admissions prior to their admission to the SCU for compliance. ED or designee will review all new admits admitted monthly.

Completion Date: *05/26/2021*

231d No objection statement

1. **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 Repeat Violation

Resident #4 was admitted to the SCU on [redacted]. However, the resident's record does not include documentation that the resident and the resident's designated person or the resident's family have agreed to the resident's admission to the SCU.

Repeat Violation: 01/02/2020 et al, 10/04/2019 et al

Plan of Correction **Accept**

Responsible Party/Resident #4's agreement to reside in the SCU was signed on [redacted] and was included in the receipt of documents given to the responsible party/resident, labeled Memory Care Program Description. Both the resident and the responsible party agreed and signed for possession of these agreements. An audit will be conducted on all residents currently on the SCU unit to ensure compliance from May 1, 2021 thru May 16, 2021. An in-service was conducted on May 6, 2021 and on all shifts thru May 16, 2021 for all Sales Team Members, Administration Staff and Clinical Staff regarding the requirement of documentation that the resident and the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit. RSD has completed a spreadsheet to track compliance with Regulation 2800.231.d. RSD or designee will review each resident admission or transfer to the SCU for this documentation, prior to transfer or admission to the Unit. ED or designee will conduct audits on all resident admissions or transfers to the SCU daily.

Completion Date: *05/26/2021*

233c Key-locking devices

1. **Requirements**

2800.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the residence's locking mechanism are not conspicuously posted near the front and back gates in the SCU courtyard.

233c Key-locking devices *(continued)*

Plan of Correction **Accept**

On 2-9-2021, the Directions for operating the residence's locking mechanism were posted in a conspicuous place near the front and back gates in the SCU courtyard. On 4-1-2021 an in-service was completed for all staff. On 5-6-2021 we will repeat the in-service and continue thru 5-16-2021 to attain 100% participation. ESD or designee will monitor daily during rounds to ensure compliance. This will be added to the TELS work order system.

Completion Date: *05/26/2021*