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

February 3, 2023

[redacted]
EC OPCO ALLISON PARK LLC
[redacted]

RE: CELEBRATION VILLA OF ALLISON PARK
2224 WALTERS ROAD
ALLISON PARK, PA, 15101
LICENSE/COC#: 44900

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/13/2022, 12/14/2022, 12/15/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CELEBRATION VILLA OF ALLISON PARK* **Licen e #**: *44900* **Licen e Expiration**: *01/10/2023*

Address: *2224 WALTERS ROAD, ALLISON PARK, PA 15101*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *EC OPCO ALLISON PARK LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/07/1997* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *39* **Waking Staff**: *29*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *12/15/2022*

Inspection Dates and Department Representative

12/13/2022 - On-Site: [redacted]
12/14/2022 - On-Site:
12/15/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: *95* **Re ident Served**: *33*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Re ident Served:**

Hospice

Current Re ident : *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

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

Have Mobility Need: *6* **Have Physical Disability**: *0*

Inspections / Reviews

12/13/2022 Full

Lead Inspector [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/31/2022*

Inspections / Reviews *(continued)*

01/04/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/10/2023*

01/11/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/30/2023*

02/03/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2023*

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

16b - Incident Policies

1. Requirements

2600.
16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home does not written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Plan of Correction ***Accept [redacted] - 01/11/2023)***

On 12/17/2022 the written policy and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions was located on the SharePoint drive, printed and placed in the policy book by the Executive Director.
On 12/20/2022 the Executive Director educated the Administrative Assistant and Clinical Leadership team on 2600.16b and location of policies on PLC SharePoint drive.
The Director of Nursing reviewed incident reporting procedure with direct care staff on 12/21/2022.
Documentation will be kept in training file for the education completed with leadership and direct care staff.
Executive Director and Clinical leadership team will monitor daily for compliance and all incidents will be reviewed on a monthly basis at the QA meeting held each month between the 21st and 25th.

Licensee's Proposed Overall Completion Date: *01/10/2023*

Implemented [redacted] - 02/02/2023)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - 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).

Description of Violation

A Pennsylvania criminal background check was not completed for staff person A, who was hired on [redacted]22.

A Pennsylvania criminal background check was not completed for staff person B, who was hired on [redacted]/19.

A Pennsylvania criminal background check was not completed for staff person C, who was hired on [redacted]20.

Plan of Correction ***Accept (LM - 01/11/2023)***

On 12/19/2022 the Executive Director located PA Epatch criminal background checks for staff A, B, and C.
On 12/19/2022 the Executive Director provided training to the Director of Nursing and Administrative Assistant on how to order and run new background checks for any new hires and/or any staff member that is missing the required document. Documentation will be kept in staff training file for education completed with leadership.
On 12/20/2022 the Executive Director provided training to the Administrative Assistant on how to review staff files and use checklist to ensure all required documents are in place. Documentation will be kept in staff training file for

51 - Criminal Background Check (continued)

education completed with Administrative Assistant.
The Executive Director and Administrative Assistant will monitor all new hire paperwork to ensure all have required documents and review at monthly QA meeting held each month between the 21st and 25th.
On 12/20/2022 the Executive Director and Administrative Assistant completed an audit of all current staff files to ensure all required paperwork was completed and placed into employee files. A new employee checklist is completed for each employee file and will kept at the front of each employee file.

Licensee's Proposed Overall Completion Date: *01/10/2023*

Implemented [redacted] - 02/02/2023)

54a Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person B, hired on [redacted]/19, does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Direct care staff person C, hired on [redacted]/20, does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed [redacted] 01/11/2023)***

On 12/20/2022 the Executive Director provided training to the Administrative Assistant on PA Code Title 55 for Direct Care Staff Qualifications. Documentation will be kept in staff training file for education provided to admin assistant.
On 1/4/2023 the Executive Director provided training to the admin assistant on the hiring process to ensure qualifications are obtained at the time of hire. Documentation will be kept in staff training file for education provided to the admin assistant.
On 12/19/2022 the Executive Director located Direct care staff B high school diploma.
On 12/19/2022 the Executive Director located Direct care staff C collage transcripts and acceptance letter on file.
On 12/20/2022 the Executive Director provided training to the administrative assistant on PA Code Title 55 for Direct Care Staff Qualifications. Documentation of education provided to admin assistant will be kept in staff training file.
The Executive Director and Administrative Assistant will ensure all new hires have a high school diploma or GED on file and all new hire paperwork will be reviewed monthly at Quality Assurance Meeting starting January 2023 with meeting held by the 25th of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 1/11/23).

DIRECTED: Within 7 calendar days of receipt of the plan of correction: The administrator shall develop and

54a - Direct Care Staff (continued)

mplement a new hire checklist to ensure qualifications are obtained in accordance with 2600.54a at the time of hire for all newly-hired direct care staff persons. Copies of the qualifications shall be kept in each staff person's record. Copies of the completed checklists shall be kept in each staff person's record. [redacted] 1/11/23.

Directed Completion Date: *01/25/2023*

Implemented [redacted] - 02/02/2023)

63a First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On numerous dates and times, to include the following, there were no staff persons present in the home who are currently trained in first aid and certified in obstructed airway techniques and CPR:

- *12/9/22 from approximately 10:30 PM through 6:30 AM*
- *12/10/22 from approximately 10:30 PM through 6:30 AM*
- *12/12/22 from approximately 8:00 PM through 10:30 PM*

Plan of Correction ***Accept [redacted] 01/11/2023)***

On 12/19/2022 the Executive Director printed the certifications along with the training sign-in page for staff persons working on 12/9/22, 12/10/22, and 12/12/22 that were all trained in Adult CPR and First Aid on 12/2/2022 by American Red Cross Instructor. The certifications were not printed and placed in the employee files due to server maintenance on the site.
An audit of all staff employee files was conducted on 12/20/2022 to ensure direct care staff have current CPR and first aid. Employee file checklist will be kept at the front of each employee file.
The Executive Director will provide training to the Administrative Assistant and Director of Nursing on regulation 63a by 1/10/2023. Documentation of education provided to leadership will be kept in the staff training file.
Executive Director and/or Administrative Assistant will review employee training monthly at QA meeting starting at January 2023 with meeting held by the 25th of each month.

Licensee's Proposed Overall Completion Date: *01/10/2023*

Implemented [redacted] - 02/02/2023)

65a - FS Orientation 1st Day

5. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.

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

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 on [redacted]19, did not receive orientation on any of the topics specified in 2600.65a.

Direct care staff person C, hired on [redacted]/20, did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction ***Directed [redacted] - 01/11/2023)***

Direct care staff B did receive orientation on all topics and signed training form on [redacted]/2019.
Direct care staff C did receive orientation on all topics and signed training form on [redacted]2020.
On 12/19/2022 the Executive Director located these documents and placed into employee files.
On 12/20/2022 the Executive Director has provided training to the Administrative Assistant on using employee file checklist along with new hire orientation checklist to ensure that all staff administrative files are in compliance with the PA Regulation 65a. Documentation of education provided will be kept in staff training file.
On 12/20/2022 the Executive Director and Administrative Assistant completed an audit of all current staff files to ensure all required paperwork was completed and placed into employee files. A new employee checklist is completed for each employee file and will kept at the front of each employee file. (DIRECTED: The new employee checklist shall be implemented within 7 calendar days of receipt of the plan of correction to ensure all newly hired staff persons receive training on all topics specified in 2600.65a prior to or during their first work day. Documentation of the trainings shall be kept in each staff person's record. Copies of the completed new hire checklists shall be kept in each staff person's record. [redacted] 1/11/23).
The Executive Director and Administrative assistant will monitor for compliance that each new hire has received 1st day training and all new hire training will be reviewed at monthly QA meeting starting at January 2023 with meeting held by the 25th of each month (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 1/11/23).

Directed Completion Date: *01/25/2023*

Implemented ([redacted] - 02/02/2023)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.

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

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff person B, hired on [redacted]19, did not receive orientation on any of the topics specified in 2600.65b.

Direct care staff person C, hired on [redacted]/20, did not receive orientation on any of the topics specified in 2600.65b.

Plan of Correction ***Directed (LM - 01/11/2023)***

12/19/2022 Executive Director located the training binder that had the 40 hour training for staff B originally received on [redacted]/2019, and staff C originally received on [redacted]/2020.
The training binder that contained all original trainings was located in the chart storage area, placed there from the previous Administrator.
The Executive Director held a refresh training on 65b with all current staff on 12/21/2022. Both original and new training documentation for the education will be kept in the staff training files.
On 12/20/2022 The Executive Director trained the Administrative Assistant on using employee file checklist along with the new hire orientation checklist to ensure all staff admin files are in compliance with PA regulation. Documentation will be kept for education provided in the training binder. (DIRECTED: The new employee checklist shall be implemented within 7 calendar days of receipt of the plan of correction to ensure all newly hired staff persons receive training on all topics specified in 2600.65b within 40 scheduled working hours. Documentation of the trainings shall be kept in each staff person's record. Copies of the completed new hire checklists shall be kept in each staff person's record. [redacted]1/11/23).
Employee files will be reviewed each month to ensure all required documents are present in the file at the QA meeting starting at January 2023 with meeting held by the 25th of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 1/11/23).

Directed Completion Date: *01/25/2023*

Implemented [redacted] - 02/02/2023)

65d - Initial Direct Care Training

7. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

65d - Initial Direct Care Training *(continued)*

Description of Violation

Direct care staff person B, hired on [redacted]19, has not successfully completed and passed the Department-approved direct care training course and has not passed the competency test.

Direct care staff person C, hired on [redacted]/20, has not successfully completed and passed the Department-approved direct care training course and has not passed the competency test.

Plan of Correction ***Directed [redacted] - 01/11/2023)***

Direct care staff B completed direct care staff training course and competency on [redacted]/2019.
Direct care staff C completed direct care staff training course and competency on [redacted]/2020.
On 12/19/2022 the Executive Director located the training binder containing al original staff required training in the chart storage area, placed there by previous administrator.
On 12/20/2022 the Executive Director has trained the Admin assistant on 65d. Documentation of education provided will be kept in the training file.
On 12/20/2022 The Executive Director and Admin assistant completed an audit of all employee files to ensure that all required training and documents are present and available.
The Executive Director and Administrative assistant will monitor for compliance with all new hires to complete direct care staff competency testing and all new hire paperwork/training will be reviewed at monthly QA meeting starting at January 2023 with meeting held by the 25th of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 1/11/23).

DIRECTED: Within 7 calendar days of receipt of the plan of correction: The administrator shall develop and mplement a new hire checklist to ensure each newly-hired direct care staff person successfully completes and passes the Department-approved direct care training course and passes of the competency test prior to performing unsupervised direct care services to residents. Documentation of the successful completion of the Department-approved direct care competency course shall be kept in each staff person's record. Copies of the completed checklists shall be kept in each staff person's record [redacted] 1/11/23.

Directed Completion Date: *01/25/2023*

Implemented [redacted] - 02/02/2023)

88a Surfaces

8. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

88a - Surfaces *(continued)*

Description of Violation

On 12/13/22, the fire-rated doors in the hallway from the dining room leading to the 300 hallway did not completely close when disengaged from the magnetic release, and had to be physically pushed shut.

Plan of Correction ***Directed [redacted] - 01/11/2023)***

The maintenance director repaired the fire-rated doors in the hallway from the dining room leading to the 300 hallway while inspector was on site 12/13/2022.
On 1/6/2023 The Executive Director provided education to the Maintenance Director on regulation 88a. Documentation of education provided will be kept in training file.
On 1/6/2023 The Executive Director provided training to all staff on 88a and reporting procedures of any issues that need repaired or replaced to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Documentation of education provided will be kept in training file.
The Maintenance Director or the Manager on Duty will walk the community weekly beginning 1/4/2023 to ensure in compliance, with emphasis on all doors.
The Maintenance director and executive director will review any findings/issues at the monthly QA meetings starting at January 2023 with meeting held by the 25th of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 1/11/23).

Directed Completion Date: *01/25/2023*

Implemented [redacted] 02/02/2023)

121a Unobstructed Egress

9. Requirements

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

Description of Violation

On 12/13/22 at 11:24 AM, the emergency exit door near bedroom [redacted] could not be opened without excessive force.

Plan of Correction ***Accept [redacted] 01/11/2023)***

The emergency exit door near bedroom [redacted] was repaired on 12/13/2022 while the inspector was on site.
On 1/6/2023 the Executive Director educated the Maintenance Director on regulation 121a. Documentation of education provided will be kept in training file.
On 1/6/2023 the executive director educated all staff on 121a which includes reporting procedures of any issues with any doors which may need repaired or replaced to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Documentation of education provided will be kept in training file.
Beginning 1/4/2023 the Maintenance Director and/or the Manager on Duty will perform daily walk around of the community to ensure all doors are working properly and unobstructed.

Licensee's Proposed Overall Completion Date: *01/10/2023*

Implemented [redacted] - 02/02/2023)

126a - Furnace Inspection

10. Requirements

2600.
126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

There is no documentation present indicating the home's 9 furnaces have been inspected by a professional furnace company or trained maintenance staff person within the past year.

Plan of Correction ***Directed [redacted] - 01/11/2023)***

On 12/13/2022 the furnace inspection was scheduled while the inspector was on site.
he inspection of all 9 furnaces was completed on 12/16/2022. (DIRECTED: Documentation of the furnace nspections shall be kept. [redacted] 1/11/23).
he Maintenance Director and/or Executive Director will monitor for compliance of annual furnace inspections. A review of all inspections and upcoming inspection dates will be completed monthly beginning 1/24/2023 at QA meetings held each month starting at January 2023 with meeting held by the 25th of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 1/11/23). Tels online monitoring/tracking system will be used to keep track of all upcoming safety inspections at the community.

Directed Completion Date: *01/25/2023*

Implemented [redacted] - 02/02/2023)

132a - Monthly Fire Drill

11. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

No fire drills were conducted in December, 2021 or January, 2022.

Plan of Correction ***Directed [redacted] 01/11/2023)***

Maintenance Director will hold monthly fire drills rotating between morning and evening shifts, with an overnight during hours of sleep drill held every quarter.
On 12/29/2022 the Executive Director educated all members of leadership on regulation 132a. Documentation of education will be kept in training file. Monthly unannounced fire drills to be conducted and documentation kept utilizing both state form and in electronic tracking system TELS.
Beginning 1/24/23 the Maintenance Director and/or Executive Director will monitor monthly that fire drills occur, documentation kept and reviewed at monthly QA meeting starting at January 2023 with meeting held by the 25th of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 1/11/23).

Directed Completion Date: *01/25/2023*

Implemented [redacted] - 02/03/2023)

141a 1-10 Medical Evaluation Information

12. Requirements

2600.
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.

Description of Violation

Resident #4's medical evaluation, dated [redacted]/22, does not include a list of current medications. This section of the form is blank. Resident #4 is prescribed numerous medications, to include [redacted] tablets and [redacted] tablets.

Plan of Correction ***Directed [redacted] - 01/11/2023)***

A new DME was requested from the Physician for resident #4 on 12/19/2022.
A new signed DME was received from the Physician for resident #4 on 1/4/2023.
An audit of all current residents DME will be completed by 1/30/2023 to ensure all are completed in entirety and signed by the Physician.
The Director of Nursing and/or Resident Care Coordinator will use a tickler system to track and monitor when DMEs are due to be completed on time (DIRECTED: Documentation of the tickler system shall be kept. [redacted] 1/11/23). The Executive Director and Admin Assistant will review each new DME for completeness before filing. (DIRECTED: Beginning on 1/20/23: The Executive Director or Administrative Assistant shall review each new medical evaluation within 48 hours of completion to ensure each resident has a medical evaluation, completed in its entirety, within 60 days prior to admission or within 30 days after admission. [redacted] 1/11/23).
Executive Director will educate all members of leadership on regulation 141a by 1/30/2023. Documentation of education provided will be kept in training file.

Directed Completion Date: *01/30/2023*

Implemented [redacted] - 02/02/2023)

141b1 - Annual Medical Evaluation

13. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed on [redacted]/21.

Plan of Correction ***Directed [redacted] - 01/11/2023)***

A new DME was requested from the Physician for resident #2 on [redacted]-2022.

141b1 - Annual Medical Evaluation (continued)

A new signed DME was received from the Physician for resident #2 on [redacted] 2023.
An audit will be conducted on all current residents DME to ensure completed timely/annually by 1/30/2023. A tickler system was created 12-19-22 and will be utilized to track when annual DME will be due. (DIRECTED: Documentation of the tickler system shall be kept. [redacted] 1/11/23).
Executive Director educated the clinical leadership team on regulation 141b on 1-6-2023. Documentation of education will be kept in training file.
Director of Nursing and/or Resident Care Coordinator will monitor weekly for compliance that DME are completed timely and completely utilizing tickler system. (DIRECTED: The weekly monitoring shall begin on 1/20/23.[redacted] 1/11/23).

Directed Completion Date: *01/30/2023*

Implemented [redacted] - 02/02/2023)

185a - Implement Storage Procedures

14. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 12/14/22, the following prescribed medications for resident #1 were not available in the home for administration:

- [redacted] *once daily as needed*
- [redacted] *by mouth every 2 hours as needed*

Plan of Correction ***Directed (LM - 01/11/2023)***

Resident #1 [redacted] was discontinued by Physician on 12/29/2022.
Resident #1 [redacted] was discontinued by Physician on 12/29/2022.
An audit of all current medications will begin 12/20/22 and be completed by 1/15/2023 to ensure all prescribed medications are available at the community.
Executive Director and Regional nurse educated the Director of Nursing and Resident Care Coordinator on regulation 185a on 12/20/2022. Documentation of education will be kept in training file.
Director of Nursing will re-educate all medication techs on proper reorder of medication procedure by 1/30/2023. Documentation of education will be kept in training file.
Director of Nursing and/or Resident Care Coordinator will do weekly medication audits beginning 1/1/2023 to ensure all medication are on hand and results of audit will be reviewed at monthly QA meeting starting at January 2023 with meeting held by the 25th of each month. (DIRECTED: Documentation of the quality management reviews shall be kept [redacted] 1/11/23).

Directed Completion Date: *01/30/2023*

Implemented [redacted] - 02/03/2023)

187a - Medication Record

15. Requirements

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

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

Description of Violation

Resident #1 is prescribed [redacted] by mouth 3 times daily. However, resident #1's December 2022 MAR includes 2 entries for the same medication.

Plan of Correction ***Directed ([redacted] - 01/11/2023)***

Residents MAR double entry was corrected on 12/28/2022. An audit of all current residents MAR began 12/28/22 and is to be completed by 1/20/2023 to ensure accurate and no double entries.
On 12/20/2022 the Executive Director and Regional Nurse educated the Director of nursing and Resident Care Coordinator on regulation 185a. Documentation of education will be kept in training file. (DIRECTED: Within 7 calendar days of receipt of the plan of correction: The DON and Resident Care Coordinator shall be educated on MAR requirements in accordance with 2600.187a. Documentation of the education shall be kept. [redacted] 1/11/23)
The Director of Nursing will re-educate all medication techs on proper reorder of medication procedures by 1/30/2023. Documentation of education will be kept in training file.
On 1/1/2023 The Director of Nursing and/or Resident Care Coordinator will do weekly medication audits to ensure all MAR are correct and results of audit will be reviewed at the monthly QA meeting starting at January 2023 with meeting held by the 25th of each month. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 1/11/23).

Directed Completion Date: *01/30/2023*

Implemented ([redacted] - 02/03/2023)

187b - Date/Time of Medication Admin.

16. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 12/10/22 and 12/11/22, the home's electronic MAR system (E-MAR) went offline; however, no paper backup MAR's were completed for medication administration to residents on these days.

187b - Date/Time of Medication Admin. (continued)

Plan of Correction ***Accept [redacted] - 01/11/2023)***

On 12/20/2022 Regional Nurse educated the Director of Nursing and Resident Care Coordinator that each medication laptop has a local install so are still able to administer medications when the internet goes down and that Pharmacy should be contacted if issues arise immediately.
Director of Nursing will educate all medication technicians on what to do if issues with medication laptop/internet by 1/30/2023. Documentation of education provided will be kept in training file.
On 1/1/2023 the Director of Nursing and/or Resident Care Coordinator will monitor daily medication administration process is operational and if issue occur will be addressed immediately with the pharmacy for issue to be resolved.

Licensee's Proposed Overall Completion Date: *01/10/2023*

Implemented ([redacted] 02/02/2023)

187d - Follow Prescriber's Orders

17. Requirements

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

Description of Violation

According to resident #1's December 2022 MAR, resident #1 was not administered numerous medications on numerous dates and times, to include the following:

- *[redacted]-Take1 tablet by mouth 3 times daily. This medication was not administered to resident #1 at [redacted] PM and [redacted] PM on [redacted]/22 through [redacted]/22*
- *[redacted]-Take 1 tablet by mouth at bedtime. This medication was not administered to resident #1 daily at bedtime from [redacted]/22 through [redacted]/22*
- *[redacted]-Take 1 tablet by mouth twice daily. This medication was not administered to resident #1 at [redacted] AM on [redacted]/22, [redacted]/22, [redacted]/22, and [redacted]/22, and at [redacted] PM on [redacted]/22 and [redacted]/22*
- *[redacted]-Take 1 capsule by mouth at bedtime. This medication was not administered to resident #1 at bedtime on [redacted]/22 through [redacted]/22*
- *[redacted]Take 1 tablet by mouth twice daily. This medication was not administered to resident #1 at [redacted] PM on [redacted]/22*

Resident #2 is prescribed [redacted]-Take 1 tablet by mouth once daily; however, according to resident #2's December 2022 MAR, this medication was not administered to resident #2 on [redacted]/22 and [redacted]/22.

Resident #3 is prescribed [redacted]Take 1 tablet by mouth at bedtime; however, according to resident #3's December 2022 MAR, this medication was not administered to resident #3 on [redacted]/22.

According to resident #4's December 2022 MAR, resident #4 was not administered the following medications on the following dates and times:

- *[redacted]Apply topically [redacted] twice daily. This medication was not administered to resident #4 at [redacted] M on [redacted]/22 and [redacted] AM on [redacted]/22*

187d - Follow Prescriber's Orders (continued)

- [redacted]*-Take ½ tablet (25 mg) by mouth daily at bedtime. This medication was not administered to resident #4 at bedtime on* [redacted]*/22.*

Plan of Correction ***Directed*** [redacted] ***- 01/11/2023)***

Director of Nursing reviewed regulation 187d with medication technicians on 12/19/2022.Proper documentation of refusal of medications and action to take if medication needs refilled or not in community to notify pharmacy and clinical leadership and how to ensure all medications are administered as ordered utilizing missed order report on 12-19-22 and will be reviewed again at the January 24th staff meeting.
An audit of residents 1, 2, and 3 MAR and medication available was conducted by resident care coordinator to ensure meds available and proper documentation of missed or refused medication followed on 12/21/2022. An audit of all current residents medications were performed to ensure all meds available and MAR documentation is occurring properly by 1/30/2023.
ON 12/21/22 Synchrony pharmacy completed a cart exchange audit to ensure all medication available and reordered any medications running low.
Regional Nurse Educated Director of Nursing and Resident Care coordinator on electronic tools/report that can be used to help monitor that residents receive prescribed medication on time on 12/20/2022. Tools will identify if medication was not documented correctly.
1/4/23: Director of Nursing and/or Resident Care Coordinator will monitor daily residents medication record to ensure documenting correctly and timely by running electronic reports to ensure all medication documented correctly and follow up on any issues found.

DIRECTED: Beginning on 1/15/23: The DON or Resident Care Coordinator shall review the medications and MAR's for at least 5 residents per week for 6 months, then monthly thereafter, to ensure all prescribed medications are present in the home and available for administration in accordance with prescribers' orders, and that proper medication administration is present on resident MAR's. Documentation of the audits shall be kept. [redacted] *1/11/23*

Directed Completion Date: *01/30/2023*

Implemented [redacted] ***- 02/03/2023)***

225a - Assessment 15 Days

18. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #4 was admitted to the home on [redacted] *22; however, resident #4's initial assessment, signed by the assessor on* [redacted] *22, does not indicate the date the assessment was finalized. This section of the form is blank. Also, resident #4's assessment does not include an assessment of resident #4's hearing, communication, olfactory or tactile needs. These sections of resident #4's assessment are also blank.*

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Directed (LM 01/11/2023)***

Director of Nursing updated Resident #4 RASP on 1/8/2023.
An audit of all current residents RASP will be conducted by 1/30/2023.
Executive Director will re-educate Director of Nursing and Resident Care Coordinator on regulation 225a by 1/15/2023. Documentation of education will be kept in training file.
Executive Director and/or Clinical leadership team member will review each new RASP 24 hours after completion to ensure filled out in entirety with signatures, prior to filing into chart that it is fully completed correctly. (DIRECTED: The RASP reviews shall begin on 1/20/23. LM 1/11/23).

Directed Completion Date: *01/30/2023*

Implemented [redacted] - 02/03/2023)

225c - Additional Assessment

19. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Pages 4 through 12 of resident #2's most recent assessment, dated [redacted]22, are blank and does not include an assessment of numerous areas, to include resident #2's supervision, mobility or medication needs.

Plan of Correction ***Directed [redacted] 01/11/2023)***

Director of Nursing updated Resident #4 RASP on 12/29/2022.
An audit of all current residents RASP will be conducted by 1/30/2023 to ensure completion in entirety.
Executive Director will re-educate Director of Nursing and Resident Care Coordinator on regulation 225c by 1/15/2023.
Prior clinical leadership team did not complete prior RASP completely. New clinical leadership team changed in 9/2022
Executive Director and/or Clinical leadership team member will review each new RASP prior to filling in chart to ensure the RASP is fully completed. (DIRECTED: Beginning on 1/20/23: The Executive Director or DON shall review each resident's assessment and support plan within 24 hours of completion to ensure each resident has an assessment completed in its entirety at least annually. [redacted] 1/11/23).

DIRECTED: Within 72 hours of receipt of the plan of correction: The DON shall complete pages 4 through 12 of resident #1's assessment. A copy of resident #1's completed assessment shall be kept in the resident's record. [redacted] 1/11/23

Directed Completion Date: *01/23/2023*

Implemented [redacted] - 02/03/2023)

225c - Additional Assessment *(continued)*

227a - Support Plan 30 Days

20. Requirements

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

Description of Violation

Resident #1's initial assessment, dated [redacted]22, indicates numerous diagnoses, to include [redacted], [redacted], [redacted] and [redacted]; however, resident #1's initial support plan, dated [redacted]22, does not include the specific plan to meet each of these separate medical needs. The plan for each diagnoses only indicates, "DCS as well as nursing staff will administer all medications as per MD order".

Resident #1's initial support plan, dated [redacted]22, does not include resident #1's [redacted] for ambulation.

Resident #3's initial support plan, dated [redacted]21, does not include a plan to meet the following medical needs, the frequency of services or the responsible party. These sections of the support plan are blank:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Resident #4 was admitted to the home on [redacted]/22; however, resident #4's initial support plan, signed by the assessor on [redacted]/22, does not indicate the date the support plan was finalized. This section of the form is blank. Also, resident #4's support plan does not include resident #4's date of birth or contact information for resident #4's designated person. These sections of the form are also blank.

Resident #4's initial assessment, signed by the assessor on [redacted]/22, indicates resident #4 has a [redacted]; however, resident #4's initial support plan, signed by the assessor on [redacted]22, does not include a description of the service needs, the plan to meet the needs, the frequency of services or responsibly party. These sections of the form are blank.

Plan of Correction ***Directed ([redacted] - 01/11/2023)***

Director of Nursing completed new updated RASP for resident #1, #3, #4 on 12/29/2022.
An audit of all current residents RASP will be conducted by 1/30/2023 to ensure completed in its entirety and all areas have been addressed.
Executive Director will re-educate Director of Nursing and Resident Care Coordinator on regulation 227a by 1/15/2023.
Executive Director and/or Clinical leadership team member will review each new RASP prior to filling in chart that

227a - Support Plan 30 Days (continued)

completed fully.
Prior clinical leadership team did not complete prior RASP completely. New clinical leadership changed in 9/2022. (DIRECTED: Beginning on 1/20/23: The Executive Director or DON shall review each resident's assessment and support plan within 24 hours of completion to ensure each resident has a support plan, completed in its entirety, within 30 days of admission. [redacted] 1/11/23).

Directed Completion Date: *01/30/2023*

Implemented ([redacted] 02/03/2023)

227g Support Plan Signatures

21. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's support plan, dated [redacted]/22, is not signed by the assessor or resident #1, and does not indicate if resident #1 was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction ***Directed [redacted] - 01/11/2023)***

12/29/2022 Director of Nursing completed a new updated RASP on Resident #1 and both assessor and resident signed the RASP.
An audit of all current residents RASP will be conducted to ensure they all have appropriate signatures by 1/30/2023
Executive Director will re-educate Director of Nursing and Resident Care Coordinator on regulation 227g by 1/15/2023. Documentation of education will be kept in training file.
Executive Director and/or Clinical leadership team member will review each new RASP within 24 hours of completion to ensure filled out in entirety, prior to filling in chart that have appropriate signatures. (DIRECTED: The RASP reviews shall begin on 1/20/23. [redacted] 1/11/23).

Directed Completion Date: *01/30/2023*

Implemented [redacted] - 02/03/2023)