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

November 13, 2023

[redacted]
MARS HOLDING INC
[redacted]

RE: ROSECREST ASSISTED LIVING RESIDENCE
1000 GRAHAM WAY, P.O.BOX 1285
MARS, PA, 16046
LICENSE/COC#: 44445

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/16/2023, 05/17/2023, 05/22/2023 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: *ROSECREST ASSISTED LIVING RESIDENCE* **License #**: *44445* **License Expiration**: *06/21/2024*

Address: *1000 GRAHAM WAY, P.O.BOX 1285, MARS, PA 16046*

County: *BUTLER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *MARS HOLDING INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *04/11/2011* **Issued By**: *Mars Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *05/17/2023*

Inspection Dates and Department Representative

05/16/2023 - On-Site: [redacted]
05/17/2023 - On-Site: [redacted]
05/22/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30* **Residents Served**: *28*

Special Care Unit

In Home: *Yes* **Area**: *Whole Building* **Capacity**: *30* **Residents Served**: *28*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *28*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *28* **Have Physical Disability**: *0*

Inspections / Reviews

05/16/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/11/2023*

Inspections / Reviews *(continued)*

06/15/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/11/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/19/2023*

06/23/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/11/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/21/2023*

11/13/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/11/2023*

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

23a ADL assistance

1. Requirements

2800.
23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, signed [redacted]/22, for resident # 1, indicates the resident requires assistance with ambulation with a wheeled walker, managing healthcare, securing and using transportation, and making and keeping appointment. On multiple occasions from January 2023 until May 2023, the residence did not provide this assistance as required.

Plan of Correction ***Accept [redacted] - 06/14/2023)***

Administrator or designee will educate staff on adhering to the residents' plan of care and notifying administrator of non-compliance and documenting non-compliance by 6/30/2023.
Clinical notes will be monitored and reviewed each business day by the administrator or designee beginning 6/7/2023.
Non-compliant behaviors will be discussed with physician and plans of care will be updated, as needed, beginning 6/7/2023.
Findings of clinical records review will be discussed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

25b Contract signatures and renewal

2. 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

Resident #1's contract, dated [redacted]/22, was not signed by the resident.

Resident 2's contract, dated [redacted]/23, was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

All contracts will be audited for signatures by administrator or designee by 6/30/2023.
Residents 1 and 2 will sign their contracts by 6/30/2023
Staff completing resident sign-ins will be educated on obtaining resident signatures on admission agreements by 6/30/2023.
Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

25b Contract signatures and renewal *(continued)*

Implemented [redacted] - 07/13/2023)

42b Abuse/Neglect

3. Requirements

2800.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1, admitted to the residence on [redacted]/22, has a diagnosis of Hypertension, Lymphedema, and Dementia.

Resident #1 has had numerous falls with injury in the residence to include the following:
On [redacted]/22, the resident had an unwitnessed fall and was found by staff on bathroom floor.
On [redacted]/22, the resident had an unwitnessed fall, and was found by staff on the floor beside [redacted] bed. The resident had a red mark on [redacted] anterior and posterior left forearm.
On [redacted]/22, the resident had an unwitnessed fall, and was found by staff on the floor in Monarch cottage. The resident had a right elbow skin tear.
On [redacted]/23, the resident had a witnessed fell after getting up from the couch. The resident had right hip and arm pain, and a right elbow abrasion. The resident was taken to emergency room and diagnosed with a broken elbow and instructed to follow-up with primary care physician (PCP).
On [redacted]/23, the resident had an unwitnessed fall. The resident was transported to the emergency room and received a CT scan of the head and spine. The resident was instructed to follow-up with PCP within 3-5 days.
On [redacted]/23, the resident had an unwitnessed fall, and was found by staff sitting in the floor of bedroom [redacted] unwitnessed fall. The resident had a right flank abrasion and bruise.
On [redacted]/23, the resident had an unwitnessed fall, and was found by staff on the floor.
On [redacted]/23, the resident had an unwitnessed fall, and was found by staff crawling on floor in Monarch living room.
On [redacted]/23, the resident had an unwitnessed fall, and was found by staff on the floor of Pebble Brooke living room. The resident had a right elbow skin tear.
On [redacted]3/23, the resident had an unwitnessed fall, and was found by staff on the floor by bedroom [redacted].
On [redacted]/23, the resident had an unwitnessed fall, and was found by staff laying on [redacted] back on the floor. The resident had an, abrasion on the right knee.
On [redacted]/23, the resident went into bedroom [redacted] the resident of room [redacted] became upset and pushed resident #1 to the floor. Resident #1 had head, upper and lower back, and knee pain. The resident was transported to the ER. The resident was instructed to follow-up with PCP within 3-5 days.
On [redacted]/23, the resident had a witnessed fall, the staff observed the resident falling to the floor after getting up from dining room table. The resident had right elbow, bilateral knee, and back pain.
On [redacted]/23, the resident had an unwitnessed fall, and staff found the resident crawling on the floor by [redacted]r bedroom.
On [redacted]/23, the resident had an unwitnessed fall, and was found by staff on the floor next to [redacted] bedroom.
On [redacted]/23, the resident had an unwitnessed fall, and was found by staff in [redacted] bedroom. The resident had a hematoma on back of the head.
On [redacted]/23, the resident had a witnessed fall in [redacted] bedroom. The resident had a left-hand laceration. The resident was transported to the ER and instructed to follow-up with PCP within 3 to 5 days.
On [redacted]/23, the resident had an unwitnessed fall, and was found by staff on the floor.
On [redacted]/23, the resident had a fall while on a video call with [redacted] spouse.

42b Abuse/Neglect (continued)

On [redacted]/23, the resident had an unwitnessed fall, and was found by staff in [redacted] bedroom. The resident had a right flank and elbow bruise.
On [redacted]/23, the resident had a witnessed fall after being hit with door in hallway, the resident fell in the hallway.

In addition, resident #1 had the following medical treatments / hospital visits:
On [redacted]/23, the resident was taken to the ER for observed Edema and to rule out Deep Vein Thrombosis (DVT). The resident was instructed to follow-up with PCP within 3 to 5 days.
On [redacted]/23, the resident received a mobile x-ray, and was found to have localized swelling, a mass and lump, right lower limb / pain, and swelling.
On [redacted]/23, the resident was taken to the ER, and diagnoses with Cellulitis. The resident was instructed to follow-up with PCP in 3-5 days and elevate right leg above heart several times daily to minimize swelling.

On [redacted]/23, the resident was ordered to use compression socks. The residence did not obtain, nor use, compression socks on the resident.

On [redacted]/23, the resident was ordered to have staff keep the resident's legs elevated when tolerated, and to document refusals. The residence's staff did not follow this order, and any resident refusals were not documented.

The assessment and support plan (ASP), signed [redacted]/22, for resident # 1, indicates the resident requires assistance with ambulation with a wheeled walker, managing healthcare, securing and using transportation, and making and keeping appointment. The resident's ASP indicates the residence will assist the resident with these needs. However, multiple staff interviews indicate the resident often does not ambulate with [redacted] wheeled walker, which results in many of the falls. In addition, the resident has not completed the follow-up appointments with the PCP. The only evidence of an appointment with the PCP was a video visit on [redacted]23. Therefore, the residence is not assisting with resident with these services as indicated on the ASP.

In addition, the resident's ASP has not been updated to address the resident's falls, or how the residence will assist in preventing or mitigating future falls and injures.

Plan of Correction ***Directed ([redacted] - 06/23/2023)***

R1s plan of care will be reviewed and updated by 6/30/2023.
R1 was issued a 30 day discharge notice with an effective date of [redacted]/2023.

Staff will be educated on abuse and neglect and documenting non-compliance and refusals by 6/30/2023.
Administrator or designee will ensure that ordered follow ups occur as indicated beginning 6/7/2023.
Clinical notes will be monitored and reviewed each business day by the administrator or designee beginning 6/7/2023.
Non-compliant behaviors will be discussed with physician and plans of care will be updated, as needed, beginning 6/7/2023.
Findings of clinical records review, as well as abuse/neglect reportable incidents, will be discussed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

DIRECTED PLAN:
By 7/1/23: The administrator or designee shall ensure that the resident's care needs in the area of fall prevention are met until the resident is discharged from the residence. Fall prevention interventions can include increased supervision, the use of assistive devices, or other services as recommended by the physician. All services provided

42b Abuse/Neglect (continued)

shall be documented in the resident's support plan.

Directed Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

65a Fire Safety-1st day

4. 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

Staff person A, whose first day of work was [redacted]/23, did not receive orientation on the following topics:

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.

Plan of Correction ***Accept ([redacted] - 06/14/2023)***

The administrator or designee will complete an audit of all staff training by 6/30/2023. All staff out of compliance for training will have training completed by 7/14/2023. Identified staff member A is no longer employed with the facility and will not be included in this education.

All new employees will complete required trainings prior to working on the floor beginning 6/7/2023.

Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

65a Fire Safety-1st day *(continued)*

65e Rights/Abuse 40 Hours

5. 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

Staff person A completed [redacted] 40th scheduled work hour during the week on or around [redacted]/23. However, this staff person did not complete training in the following topics:

1. Residents rights

2. Emergency Medical Plan

3. Mandatory reporting of abuse – OAPSA

4. Reporting of reportable incidents and conditions

5. Safe management techniques

6. Core competency training:

i. Person-centered care.

ii. Communication, problem solving and relationship skills.

iii. Nutritional support according to resident preference.

Plan of Correction ***Accept ([redacted] - 06/14/2023)***

The administrator or designee will complete an audit of all staff training by 6/30/2023. All staff out of compliance for training will have training completed by 7/14/2023. Identified staff member A is no longer employed with the facility and will not be included in this education.

All new employees will complete required trainings prior to working on the floor beginning 6/7/2023.

Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (JW - 07/13/2023)

65j Annual training content

7. Requirements

2800.

65j Annual training content *(continued)*

65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not receive training in the following topics during training year January 2022 to December 2022:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

3. Resident rights.

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).

5. Falls and accident prevention.

6. New population groups that are being served at the home that were not previously served, if applicable.

Plan of Correction ***Accept [redacted] - 06/14/2023)***

The administrator or designee will complete an audit of all staff training by 6/30/2023. All staff out of compliance for training will have training completed by 7/14/2023.

Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

66a Staff training plan

8. Requirements

2800.
66.a. A staff training plan shall be developed annually.

Description of Violation

The residence does not have a staff training plan for the training year January 2023 to December 2023.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

A staff training plan will be developed by 6/30/2023.

The administrator or designee will complete an audit of all staff training by 6/30/2023. All staff out of compliance for training will have training completed by 7/14/2023.

Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

The staff training plan will be reviewed annually for updates and additions effective 6/30/2023.

66a Staff training plan *(continued)*

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

81b Resident equip – good repair

9. 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

Residents #1, 2, and 3 have enabler bars attached to [redacted] beds, with uncovered openings measuring approximately 7 and 1/2 inches by 4 inches, posing entrapment hazards.

Plan of Correction ***Directed [redacted] - 06/23/2023)***

All resident beds will be audited for enabler bars by 6/23/2023.

All enabler bars not in compliance with this regulation will be changed or modified to meet the regulation by 7/14/2023.
Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

DIRECTED PLAN:
By 7/1/23: The administrator or designee shall replace or alter the current enabler bars for residents #1, #2 and #3 so that they no longer present an entrapment hazard for the residents. Acceptable alterations may include covering any openings with a manufacturer provided cover or other material that prevents entrapment of a resident's arm, leg or head.

Directed Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

101j7 Lighting/operable lamp

10. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident # 4 does not have access to a source of light that can be turned on/off at bedside. The lamp is approximately 4 feet from the bed and there is an armchair between the bed and the lamp.

Plan of Correction ***Accept [redacted] - 06/15/2023)***

The resident without a reachable light had one installed on 5/16/2023.
All resident rooms will be audited for lamps at bedside by 6/30/2023. All rooms out of compliance will have lights installed by 6/30/2023.

101j7 Lighting/operable lamp (continued)

Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (- 07/13/2023)

103f Fridge/Freezer Temps

11. Requirements

2800.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 5/16/23, at 11:48 a.m., the temperature in the stainless-steel refrigerator in the kitchen was 12 degrees Fahrenheit and on 5/17/23 at 9:54 a.m. it was 12 degrees Fahrenheit.

On 5/16/23, at 12:00 p.m., the temperature in the white refrigerator on the Monarch side of the dining room was 48 degrees Fahrenheit.

Plan of Correction ***Accept - 06/15/2023)***

Kitchen Freezer

was purchase requisitioned (PR86944) and a rush purchase order (PO65365) entered on 5/17/23 to make repairs on the stainless steel freezer unit in the kitchen. Repairs have been completed and the unit is now operating at (-2) degrees Fahrenheit.

Monarch Refrigerator/Freezer

The refrigerator/freezer in question on the Monarch side of the dining room was replaced on the morning of 5/17/23. The refrigerator/freezer was not put into service until the cooler compartment was below "40" degrees Fahrenheit and the freezer compartment was below "0" degrees Fahrenheit. Those temperature parameters were achieved and unit was put back into service.

Administrator or designee will educate staff on daily logging and monitoring of freezer and refrigerator temperatures, and immediate notification of maintenance department if temperatures exceed parameters (40 degrees for refrigerator, 0 degrees for freezer) by 6/30/2023.

Temperature logs will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (- 07/13/2023)

107a Emergency preparedness

12. Requirements

2800.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the residence is located.

107a Emergency preparedness *(continued)*

Description of Violation

Staff person D, [redacted], did not have a copy and was not familiar with the emergency preparedness plan for the municipality in which the residence is located.

Plan of Correction ***Accept [redacted] - 06/15/2023)***

The emergency plan for Butler County was placed in the emergency preparedness manual on 6/7/2023.
Upon the yearly emergency preparedness review, the county plan will be checked to ensure it is in the manual and updated. The next yearly review is 9/30/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] 07/13/2023)

131f Fire extinguisher inspection

13. Requirements

2800.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

There was no date of the inspection on the fire extinguisher located in residence's van/bus that is used to transport residents.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

Bus Fire Extinguisher
A purchase requisition (PR87439-B) has been entered and submitted to [redacted] by the Maintenance Supervisor for an inspected fire extinguisher on 6/2/2023. This fire extinguisher will be added to our monthly and annual inspections list once it has been received to ensure regular inspections take place by maintenance staff. These inspections will begin by 6/30/2023.
Administrator or designee will educate bus driver on ensuring that the bus fire extinguisher is inspected monthly by 6/30/2023.
Fire extinguisher inspections will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

132c Fire drill records

14. 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 record did not include the amount of time it took for evacuation for the following fire drills:
On 4/20/23 at 5:04 a.m.

132c Fire drill records (continued)

On 3/14/23 at 8:00 p.m.
On 1/20/23 at 5:05 a.m.
On 12/15/22 at 6:38 p.m.
On 11/14/22 at 9:15 a.m.
On 10/27/22 at 12:11 a.m.
On 9/18/22 at 8:00 p.m.
On 8/25/22 at 1:10 p.m.
On 7/13/22 at 5:01 a.m.
On 6/16/22 at 8:00 p.m.
On 5/12/22 at 10:44 a.m.

In addition, the fire drills conducted on 4/20/23 at 5:04 a.m. and on 10/27/22 at 12:11 a.m. did not indicate the exit route used. That area was blank.

Repeat Violation: 3/14/22

Plan of Correction ***Accept (06/15/2023)***

Form Criteria
We have adopted the Adult Residential Licensing – Personal Care Home Fire Drill Record – 55 Pa. Code 2600.132(c) Form for use when conducting fire drills at this location beginning with the May 22, 2023 fire drill.
Administrator or designee will educate all personnel that conduct fire drills at this location on the use of the form and proper documentation procedures for the form by 6/30/2023.
Administrator or designee will audit completed fire drill records monthly beginning 6/7/2023.
Fire drill records will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented - 07/13/2023)

132d Evacuation

15. 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

Not all of the residents evacuated to a public thoroughfare or a fire safe area during the following fire drills:
On 4/20/23 at 5:04 a.m., 26 residents present in home, 2 residents were evacuated.
On 3/14/23 at 8:00 p.m., 29 residents present in home, 0 residents were evacuated.
On 1/20/23 at 5:05 a.m., 3 residents present in home, 0 residents were evacuated.
On 7/13/22 at 5:18 a.m., 24 residents present in the home, 0 residents were evacuated.
On 6/16/22 at 8:00 p.m., 11 residents present in the home, 0 residents were evacuated.

Plan of Correction ***Accept (- 06/15/2023)***

Administrator or designee will educate all personnel that perform fire drills and the staff that participate in the fire

132d Evacuation (continued)

drills by 6/30/2023 on the correct procedures to be followed for each and every fire drill that is performed.
All residents, visitors, and staff, in the building will be evacuated to the designated fire-safe area. Documentation will reflect the number of residents evacuated to a fire-safe area.
Administrator or designee will audit completed fire drill records monthly beginning 6/7/2023.
Fire drill records will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] 07/13/2023)

132g Fire drills – days/times

16. Requirements

2800.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The residence routinely holds fire drills at or close to 8:00 p.m. and 5:00 a.m. as evidenced by the following drills:
On 3/14/23 at 8:01 p.m.; on 9/18/22 at 8:00 p.m.; and on 6/16/22 at 8:00 p.m.
On 4/20/23 at 5:09 a.m.; on 1/20/23 at 5:14 a.m.; and on 7/13/22 at 5:18 a.m.

Plan of Correction ***Accept [redacted] - 06/15/2023)***

Beginning 6/7/2023, the maintenance supervisor will schedule fire drills to ensure they are scheduled on various days and times.
Beginning 6/7/2023, the maintenance supervisor will put the date and time to perform the drill on each work order that is given to the drill conductor.
Beginning 6/7/2023, specific directions will be given on the work order to strictly adhere to the specified date and time. If for any reason the drill is unable to be carried out on the specified date and time; only the maintenance supervisor will set the new date/time.
Administrator or designee will educate the conductors of fire drills by 6/30/2023 on all the above criteria to ensure they understand the importance of not becoming predictable with fire drills.
Administrator or designee will audit completed fire drill records monthly beginning 6/7/2023.
Fire drill records will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

183d Current medications

17. Requirements

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

183d Current medications *(continued)*

Description of Violation

Ativan 2mg prescribed for resident # 2, was in the residence's medication cart; however, the medication expired on 12/1/22.

Repeat Violation: 3/14/22

Plan of Correction ***Accept (06/22/2023)***

The expired medication was removed from the cart and destroyed on 5/17/2023.
Administrator or designee will complete weekly audits of med carts x 4 weeks, twice monthly audits of med carts x 4 months, and monthly audits of med carts indefinitely beginning 6/7/2023.
Administrator or designee will educate staff on current medications and disposal of expired medications by 6/30/2023.
Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented - 07/13/2023)

187d Follow prescriber's orders

18. Requirements

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

Description of Violation

On 4/7/23, resident # 1 is ordered to wear compression socks. However, the residence does not have these for the resident and are not using them on the resident.

On 4/10/23, resident #1 has an order for the residence's staff to keep the resident's legs elevated when tolerated, and to document refusal. Multiple staff interviews indicate the resident is not having legs elevated and this is not documented.

Plan of Correction ***Accept (- 06/15/2023)***

Administrator or designee will educate staff on adhering to the residents' physician orders and notifying administrator of non-compliance and documenting non-compliance by 6/30/2023.
Clinical notes will be monitored and reviewed each business day by the administrator or designee beginning 6/7/2023.
Non-compliant behaviors will be discussed with physician and plans of care will be updated, as needed, beginning 6/7/2023.
Findings of clinical records review will be discussed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (07/13/2023)

231e Additional assessments

19. Requirements

2800.
231.e.1. In addition to the requirements in § 2800.225 (relating to additional assessments), residents of a special care unit for Alzheimer's disease or dementia shall also be assessed quarterly for the continuing need for the special care unit for Alzheimer's disease or dementia.

Description of Violation

Resident # 1 was assessed for the need for special care unit on [redacted]/22 and was not assessed again for this need.

Resident # 5 was assessed for the need for special care unit on [redacted]/22 and was not assessed again for this need.

Plan of Correction ***Accept [redacted] 06/22/2023)***

Resident #1's ASP was updated 4/10/2023 for a significant change and was re-assessed at that time. Resident #5 was re-assessed on 6/2/2023.
Administrator or designee will audit resident assessments for timely completion and update any out of compliance by 6/30/2023.
Staff will be educated on timely completion of assessments by 6/30/2023.
A spreadsheet of assessment due dates will be kept beginning 6/30/2023 and reviewed by the administrator or designee monthly beginning 6/30/2023.
Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

234d Support plan - review

20. Requirements

2800.
234.d.1. The support plan for a resident of a special care unit for residents with Alzheimer's disease or dementia shall be reviewed, and if necessary, revised at least quarterly and as the resident's condition changes.

Description of Violation

A support plan for resident # 1 was signed on [redacted]/22; however, the resident has had multiple falls with injuries and the support plan has not been updated to include how the residence plans to meet this need.

Plan of Correction ***Accept [redacted] 06/15/2023)***

Administrator or designee will audit resident support plans for timely completion after a significant change and update any out of compliance by 6/30/2023.
Staff will be educated on timely completion of support plans by 6/30/2023.
Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)

236a Staff training

21. Requirements

2800.

236a Staff training *(continued)*

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

Direct care staff person A, date of hire [redacted]/23, works in the special care unit, but has not completed any hours of initial training related to dementia care within the first 30 days of the date of hire.

Direct care staff person E, date of hire [redacted]/23, works in the special care unit, but has not completed any hours of initial training related to dementia care within the first 30 days of the date of hire.

Plan of Correction ***Accept [redacted] 06/15/2023)***

The administrator or designee will complete an audit of all staff training by 6/30/2023. All staff out of compliance for training will have training completed by 7/14/2023. Identified staff member A is no longer employed with the facility and will not be included in this education.
All new employees will complete required trainings prior to working on the floor beginning 6/7/2023.
Results of audits will be reviewed in QAPI meetings (the next meeting is 7/19/2023) until substantial compliance is obtained or ongoing, as needed, beginning 6/7/2023.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 07/13/2023)