pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **THE VILLAGES OF HARMAR, LLC**
LEGAL ENTITY

To operate **THE VILLAGES OF HARMAR**
NAME OF FACILITY OR AGENCY

Located at **715 FREEPORT ROAD, CHESWICK, PA 15024**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **133**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Special Care Unit - 55 Pa.Code §§ 2800.231-239 - Capacity 23**

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

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

and shall remain in effect from **December 21, 2023** until **June 21, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454561**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: DECEMBER 21, 2023

[redacted], President
The Villages of Harmar, LLC
[redacted]
[redacted]

RE: The Villages of Harmar
715 Freeport Road
Cheswick, Pennsylvania
License/COC #: 454561

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 2, 2023, August 9, 2023, August 28, 2023, August 29, 2023, August 30, 2023, September 26, 2023, September 27, 2023, and September 28, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), failure to submit an acceptable plan to correct noncompliance items, failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 454560) dated July 1, 2023 – July 1, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 21, 2023 to June 21, 2024.

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

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

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *THE VILLAGES OF HARMAR* **License #**: *45456* **License Expiration**: *07/01/2024*

Address: *715 FREEPORT ROAD, CHESWICK, PA 15024*

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

Administrator

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

Legal Entity

Name: *THE VILLAGES OF HARMAR, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *115* **Waking Staff**: *86*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *08/09/2023*

Inspection Dates and Department Representative

08/02/2023 - On-Site: [redacted]

08/09/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *133* **Residents Served**: *92*

Special Care Unit

In Home: *Yes* **Area**: *Elms* **Capacity**: *23* **Residents Served**: *23*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *92*

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

Have Mobility Need: *23* **Have Physical Disability**: *0*

Inspections / Reviews

08/02/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/21/2023*

Inspections / Reviews *(continued)*

08/22/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/25/2023*

09/05/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/04/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/13/2023*

11/22/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/13/2023*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

42e Telephone access

1. Requirements

2800.
42.e. A resident shall have access to a telephone in the residence to make calls in privacy. Non toll calls shall be without charge to the resident.

Description of Violation

Resident and staff interviews indicated the residence's telephone service was inoperable from approximately 7/3/23 until 7/10/23. During that time many residents were unable to make telephone calls in private to include resident #2.

Plan of Correction ***Directed [redacted] - 09/05/2023)***

At the time of inspection this violation had been resolved. Between the dates of 7/4 and 7/10 the phone service was restored and has been working since. The facility held resident council on Friday 8/18/2023 and no phone issues were reported. The administrator or designee will report future phone outages directly to maintenance. If maintenance is unable to resolve immediately, maintenance director or designee will contact IT support to address phone issues. If phone systems are down for an extended time, facility staff will utilize their cell phones in case of an emergency.

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator shall develop and implement a policy and procedures to ensure there is a method for residents to have access to a telephone in the residence to make calls in privacy if the home's telephone system is not operational. 9/5/23 [redacted]

Within 5 days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the home's policy and procedures to ensure there is a method for residents to have access to a telephone in the residence to make calls in privacy if the home's telephone system is not operational. Documentation of education shall be kept. 9/5/23[redacted]

Directed Completion Date: *09/04/2023* Not Implemented [redacted]/21/23)

65a Fire Safety-1st day

2. 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

The residence's records indicated that agency staff persons B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, and T all provided unsupervised direct care services without receiving an orientation in general fire safety and emergency preparedness that included the following:
(1) Evacuation procedures.

65a Fire Safety-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 residence'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 ***Directed [redacted] - 09/05/2023)***

Due to the nature of Agency staff in LTC and how inconsistent they can be in regard to working at one facility, the community has decided to educate all agency staff coming into the facility on the requirements of 2800.65 in the form of an education packet. This packet is to include educational materials that meet the requirements of 2800.65a and is to be completed prior to providing direct care to residents in the facility. Agency staff that consistently pick up assignments will have their training completed no later than 9/12/2023, or sooner if they are picking up shifts between 9/1/23 and 9/12/23. Any agency staff that picks up shifts without 2800.65 trainings completed in that time frame will meet with Administrator or designee prior to providing direct care. New agency staff will be required to complete the education packet prior to working their first shift. Administrator or designee will be responsible for this education being completed. Agency education will be kept in a folder in the administrator's office moving forward.

DIRECTED

Within 1 day of receipt of the accepted plan of correction: The administrator shall audit all new staff working in the home prior to or on the first day of work, including contracted staff, to ensure compliance with Regulation 2800.85(a). 5/9/23[redacted]

Directed Completion Date: *09/12/2023*

Implemented [redacted] 11/21/2023)

65e Rights/Abuse 40 Hours

3. Requirements

2800.

65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.
6. Core competency training that includes the following:
   i. Person-centered care.
   ii. Communication, problem solving and relationship skills.
   iii. Nutritional support according to resident preference.

Description of Violation

The residence's records indicated that agency staff person C worked in excess of forty-hours as of 7/26/23 at 7:04 a.m. but did not receive an orientation that included the following:

(1) Resident rights.

(2) Emergency medical plan.

65e 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.
(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.

The residence's records indicated that agency staff person F worked in excess of forty-hours as of 7/30/23 at 11:13 p.m. but did not receive an orientation that included 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.

Plan of Correction ***Directed [redacted] - 09/05/2023)***

Due to the nature of Agency staff in LTC and how inconsistent they can be in regard to working at one facility, the community has decided to educate all agency staff coming into the facility on the requirements of 2800.65 in the form of an education packet. This packet is to include educational materials that meet the requirements of 2800.65e and is to be completed prior to the agency staff working 40 hours. Agency staff that historically pick up assignments will have their training completed no later than 9/12/2023. Any new agency staff that picks up shifts without 2800.65 trainings completed will meet with Administrator or designee prior to providing direct care. New agency staff to the facility will be required to complete this portion of the education packet prior to working 40 hours in the facility. Administrator or designee will be responsible for this education being completed. Agency education will be kept in a folder in the administrator's office moving forward.

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator shall audit all new staff working in the home within 40 working hours, including contracted staff, to ensure compliance with Regulation 2800.85(e). 5/9/23
[redacted]

Directed Completion Date: *09/12/2023*

Implemented [redacted] - 11/21/2023)

162e Menu changes

4. Requirements

2800.

162e Menu changes *(continued)*

162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 7/9/23 the posted menu for breakfast indicated that the following menu items will be served:
Egg and Sausage Bake
Toast
Assorted Cold Cereal
However, direct care staff person [redacted], the residence's administrator, stated the home ran out of sausage and residents were served regular scrambled eggs instead. The change to the breakfast menu was not posted in a conspicuous and public place in the home in advance of the meal, and resident interviews indicated the menu changes are not communicated in advance of meals.

Plan of Correction ***Accept ([redacted] - 09/05/2023)***

In order to better serve the residents in the facility, the Administrator/designee will provide education to the dietary director and dietary staff on the requirements of 2800.162e. Education will be completed by 9/12/23. Moving forward, any changes to the menu will be posted on the dining room tables, and on nursing stations prior to mealtimes by the dietary department and direct care staff. The facility will make every effort to post these changes well in advance if able to. Administrator or designee will monitor for planned menu changes weekly starting the week of 9/4/2023 and will be responsible for notifying residents.

Licensee's Proposed Overall Completion Date: *09/04/2023*

Not Implemented [redacted]-11/21/23)

181c Self-Administer Assessment

5. Requirements

2800.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1's medical evaluation, dated [redacted]23 and initial support plan, dated [redacted]/23, both indicated the resident is unable to self-administer medications. However, staff interviews indicated that on 7/9/23 at 9:00 a.m., 1:00 p.m., and 9:00 p.m. resident #1 self-administered Oxycodone-Acetaminophen 10-325mg tablets in Unit One North resident room #[redacted]

Plan of Correction ***Directed [redacted] - 09/05/2023)***

At the time of inspection this resident is unable to self-administer medications. No change to the support plan or medical evaluation will be made. Instead, the Administrator/designee will provide education to the direct care staff responsible for medication administration to ensure medications are not stored in the resident room no later than 9/12/2023. Moving forward weekly audits of this resident's room will take place for 1 month to ensure medications are not in the room and the resident is receiving medications from direct care staff. Audits will be discussed at the facility's next QM meeting, and will begin the week of 9/4/23.

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator or designated staff person qualified to administer medications shall complete the audits indicated in the home's plan of correction. 5/9/23 [redacted]

Directed Completion Date: *09/12/2023*

Not Implemented [redacted]-11/21/23)

183d Current medications

6. Requirements

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

Description of Violation

On 8/9/23 at approximately 12:15 p.m. there was a 30-gram tube of Nystatin 100,000 USP ointment for resident #1 was found on the One North medication cart. However, resident #1's Nystatin 100,000 USP order was discontinued 7/13/23.

Plan of Correction ***Accept [redacted] - 09/05/2023)***

At the time of inspection, this medication was removed from the medication cart. Moving forward, the Administrator or designee will provide education to direct care staff regarding removing discontinued medications from the medication carts no later than 9/12/2023. After education is completed, the administrator or designee will audit the med carts weekly for two months (8 weeks) to ensure that medications are properly removed when discontinued. Audit findings to be discussed at next QM meeting.

Licensee's Proposed Overall Completion Date: *09/12/2023* Not Implemented [redacted] 11/21/23)

184a Resident meds labeled

7. Requirements

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

Description of Violation

The pharmacy label for resident #3's Fiber-Lax 625mg Tablet indicated "2 Tabs by mouth every morning and 2 tabs by mouth at bedtime." However, resident #3's medication administration record and physician's order both indicated "Take one tablet twice daily."

Plan of Correction ***Accept [redacted] - 09/05/2023)***

The facility has stickers to indicate a change of direction on a pharmacy label when an order changes. Moving forward the administrator or designee will provide education to licensed staff to place a change of direction sticker on any medication that has changed in the EMAR no later than 9/12/23. Resident 3's fiber lax will have a change of direction sticker placed on the blister pack on 9/5/2023. Moving forward the administrator or designee will conduct weekly audits of five random resident's medications to to ensure the pharmacy label matches the physician order/emar.

Licensee's Proposed Overall Completion Date: *09/12/2023* Not Implemented [redacted] -11/21/23)

185a Storage procedures

8. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The residence's medication policy states, "Accurate records of the receipt, use, and disposition of medications will be maintained on each residents' MAR and available for review." However, on 6/24/23 it was discovered by direct care staff person [redacted], the director of nursing, that direct care staff person [redacted], a general practical nurse, had signed for

185a Storage procedures (continued)

resident #1's Percocet 10-325mg tablets on 6/7/23, and that the narcotic count sheet from the medication administration record (MAR) was missing as well as 10 days or 30 tablets worth of the resident's medication. The residence was unable to account for the missing documentation or missing Percocet 10-325mg tablets.

Resident #3 is ordered Lidocaine Viscous 2% solution, 1 swish and swallow every 6 hours as needed. However, on 8/9/23 at 2:14 p.m., the medication was not on the medication cart or in the residence to be administered if requested by resident #3.

The residence's medication policy for the accountability of controlled substances indicated, "The facility will maintain a readily available record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records will be maintained with the resident's record and in such a manner to allow accurate reconciliation." However, on 8/2/23, resident #4's Oxycodone HCl 5mg tablet was not on the medication cart to administer and the residence was unable to produce a record of the disposition to allow for accurate reconciliation of the Oxycodone HCl 5mg tablets for resident #4.

Resident #4 is prescribed Oxycodone HCl Tablet 5MG, give 0.5 tablet by mouth every 4 hours as needed. However, on 8/2/23 the Oxycodone HCl Tablet 5MG was not on the medication cart or in the residence to administer if resident #4 requested the medication.

Plan of Correction ***Directed [redacted] - 09/05/2023)***

Administrator or designee will conduct whole house audit for all med carts to ensure that PRN medications are readily available to our residents if they are ordered by the physician, and will be completed by 9/22/2023. Education to be provided by administrator or designee on the home's policy for 2800.185a. This training will be completed no later than 9/15/2023. Once the whole house audit is complete, weekly audits of 3 carts per week will be conducted for one month to ensure that medications that are ordered are available for use beginning on 9/25/23. Audit findings will be discussed at the next QM meeting.

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator or designated staff person qualified to administer medications shall complete the audits indicated in the home's plan of correction. 5/9/23 [redacted]

Directed Completion Date: *09/25/2023* Not Implemented [redacted]-11/21/23)

187a Medication record

9. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
9. Administration times.

Description of Violation

Resident #4 is prescribed Artificial Eye Lubricant (white petrolatum-mineral oil) drops, instill 1 drop in each eye 6 times daily. However, resident #4's medication administration record for August 2023 did not indicate the administration times for resident #4's Artificial Eye Lubricant (white petrolatum-mineral oil) drops.

Plan of Correction ***Directed [redacted] - 09/05/2023)***

At the time of inspection, the system in place to enter orders into the EMAR goes through the facility's pharmacy, Omnicare. It has been determined that this medication was incorrectly entered without times listed in the EMAR.

187a Medication record (continued)

This specific situation was not an ongoing issue as the medication was only ordered until 8/7/2023. Based on conversation with DHS licensing representative during the most recent inspection, this has been resolved. Moving forward the administrator or designee will educate all direct care staff members that if a medication does not have a time associated with the EMAR to notify the nursing supervisor immediately. Education to be provided by 9/12/2023. A whole house audit will be conducted by the administrator or designee to ensure that every medication order has a time associated with it in the EMAR system, audit will begin the week of 9/4/23 and will be completed by 9/22/2023. Findings of this audit will be discussed at the next QM meeting.

DIRECTED
Within 1 day of receipt of the accepted plan of correction: The administrator or designated staff person qualified to administer medications shall complete a monthly audit of all resident prescription orders and MARs to ensure compliance with Regulation 2800/187(a). Documentation of audits shall be kept. 5/9/23 [redacted]

Directed Completion Date: *09/22/2023* Not Implemented [redacted]-11/21/23)

187b Date/time of med admin

10. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed Atorvastatin 20MG tablet, take 1 tablet by mouth at bedtime. However, on 8/8/23 at 9:00 p.m., direct care staff person W administered the Atorvastatin 20MG tablet to resident #4 but did not document the administration on the August 2023 medication administration record at the time of administration and there were no exceptions noted.

Resident #4 is prescribed Claritin Oral Tablet 10MG (Loratadine), give 1 tablet by mouth at bedtime. However, on 8/8/23 at 9:00 p.m., direct care staff person W administered the Loratadine 10mg tablet to resident #4 but did not document the medication administration on the August 2023 medication administration record at the time of administration and there were no exceptions noted.

Resident #5 is prescribed Levothyroxine 75mcg, take 1 tablet by mouth every morning. However, on 8/5/23 at 6:00 a.m., direct care staff person X administered the Levothyroxine 75mcg tablet to resident #5 but did not document the medication administration on the August 2023 medication administration record at the time of administration and there were no exceptions noted.

Resident #5 is prescribed Gabapentin capsule 300mg, take one capsule by mouth twice daily. However, on 7/31/23 at 9:00 a.m., direct care staff person Y administered the Gabapentin 300mg capsule to resident #5 but did not document the medication administration on the August 2023 medication administration record at the time of administration and there were no exceptions noted.

Plan of Correction ***Accept*** [redacted] ***- 09/05/2023)***

Administrator or designee will be providing whole house education to direct care staff and nursing staff on documentation in the new EMAR system, and the homes policy/procedure of 2800.187(b) no later than 9/12/23. Administrator or designee are running daily reports to identify blanks in the Emar that do not have notes associated with them. Any blanks in the EMAR will be amended so documentation is completed for medication administration. Daily reports will be run until further notice to remain in compliance with this violation. Administrator provided

187b Date/time of med admin (continued)

DHS licensing representatives copies of these resident's EMAR with corrected documentation during the facility's most recent inspection between 8/28/23-8/30/23 to show these blanks have been corrected in the EMAR.

Licensee's Proposed Overall Completion Date: *09/12/2023* Not Implemented [redacted]-11/21/23)

187d Follow prescriber's orders

11. Requirements

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

Description of Violation

Resident #3 is ordered Lamotrigine 25mg Tablet, give one tablet by mouth at bedtime. However, on 8/2/23 at 9:00 p.m., resident #3 was not administered the Lamotrigine 25mg Tablet.

Resident #4 is ordered Tamsulosin 0.4mg capsule, give one capsule by mouth every day. However, on 8/3/23, 8/5/23, and 8/6/23 resident #4 was not administered the Tamsulosin 0.4mg capsule.

Resident #4 is ordered Artificial Eye Lubricant (white petrolatum-mineral oil) drops, instill one drop in each eye 6 times a day. However, on 8/5/23, resident #4 was administered Artificial Eye Lubricant (white petrolatum-mineral oil) drops 3 times in each eye.

Resident #4 is ordered Latanoprost solution 0.005% drops, instill 1 drop in both eyes at bedtime. However, on dates ranging from 8/2/23 through 8/4/23 resident #4 was not administered the Latanoprost solution 0.005% drops.

Resident #5 is ordered Losartan 100mg tablet, give one tablet by mouth every morning. However, on the morning of 7/30/23, resident #5 was not administered the Losartan 100mg tablet.

Resident #5 is ordered Gabapentin capsule 300mg, take one capsule by mouth twice daily. However, on 7/30/23 at 9:00 p.m., resident #5 was not administered the Gabapentin capsule.

Resident #5 is ordered Famotidine 20mg tablet, take one tablet by mouth every morning. However, on 7/30/23 at 7:00 a.m., resident #5 was not administered the Famotidine tablet.

Resident #5 is ordered Levothyroxine 75mcg tablet, take 1 tablet by mouth every morning. However, on 7/29/23 at 6:00 a.m., resident #5 was not administered the Levothyroxine 75mcg tablet.

Resident #5 is ordered Blood Glucose checks once daily every Monday, Wednesday and Friday. However, on 8/4/23, resident #5's blood glucose was not measured and the exceptions noted the drug/item was not available.

Resident #5 is ordered Loratadine 10mg tablet, give 1 tablet by mouth every morning. However, on 8/7/23 resident #5's Loratadine 10mg tablet was not in the home to administer to the resident.

Plan of Correction ***Accept [redacted] 09/05/2023)***

Administrator provided licensing representatives copies of resident EMAR to show compliance after the cited dates of violation. Incident reports to be filed no later than 9/5/2023 by the administrator or designee. Administrator or designee will ensure medication errors to be reflected in resident record no later than 9/5/2023. Administrator or designee will ensure resident, resident designated persons, and providers are notified of these errors no later than

187d Follow prescriber's orders (continued)

9/5/23. Moving forward the administrator or designee will audit five random resident EMAR weekly x 4 weeks then monthly x 3 months to ensure that residents are receiving their medications as they are ordered, audits to begin the week of 9/4/23.

Licensee's Proposed Overall Completion Date: *09/05/2023* Not Implemented [redacted]-11/21/23)

224a2 30 days prior to admission

12. Requirements

2800.
224.a.2. An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

Description of Violation

Resident #6, admitted [redacted]/23, did not have an initial assessment.

Resident #7, admitted [redacted]/23, did not have an initial assessment.

Resident #8, admitted [redacted]/23, did not have an initial assessment.

Plan of Correction ***Accept [redacted] - 09/05/2023)***

Administrator or designee will complete a whole house audit of admissions from 7/1/2023 to current to ensure that everyone has had their initial assessment and support plan completed, audit completed on 8/30/2023. Any resident without an assessment or support plan will have one created and signed no later than 9/12/23. After the whole house is completed by the administrator or designee on 9/1/23 additional audits beginning the week of 9/4/23, will take place weekly to ensure nothing was missed for four weeks. Administrator or designee will create a spreadsheet to track initial, quarterly, and annual ASP for each resident in the facility by 9/12/2023 so that, moving forward the facility can track due dates of support plans.

Licensee's Proposed Overall Completion Date: *09/12/2023* Not Implemented [redacted]-11/21/23)

224c1 Initial SP-30 days prior/adm

13. Requirements

2800.
224.c.1. An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

Description of Violation

Resident #6, admitted [redacted]/23, did not have a written preliminary support plan.

Resident #7, admitted [redacted]23, did not have a written preliminary support plan.

Resident #8, admitted [redacted]23, did not have a written preliminary support plan.

Plan of Correction ***Accept [redacted] 09/05/2023)***

Administrator or designee will complete a whole house audit of admissions from 7/1/2023 to current to ensure that everyone has had their initial assessment and support plan completed, audit completed on 8/30/2023. Any resident without an assessment or support plan will have one created and signed no later than 9/12/23. After the whole house is completed by the administrator or designee on 9/1/23 additional audits, beginning the week of 9/4/23, will take place weekly to ensure nothing was missed for four weeks. Administrator or designee will create a spreadsheet to track initial, quarterly, and annual ASP for each resident in the facility by 9/12/2023 so that, moving forward the

224c1 Initial SP-30 days prior/adm (continued)

facility can track due dates of support plans.

Licensee's Proposed Overall Completion Date: *09/12/2023*

Not Implemented [redacted]-11/21/23)

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *THE VILLAGES OF HARMAR* **License #:** *45456* **License Expiration:** *07/01/2024*

Address: *715 FREEPORT ROAD, CHESWICK, PA 15024*

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

Administrator

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

Legal Entity

Name: *THE VILLAGES OF HARMAR, LLC*
Address: [redacted]
Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/24/2006* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *125* **Waking Staff:** *94*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *08/30/2023*

Inspection Dates and Department Representative

08/28/2023 - On-Site: [redacted]
08/29/2023 - On-Site [redacted]
08/30/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *133* **Residents Served:** *91*

Special Care Unit

In Home: *Yes* **Area:** *Memory Impaired Unit* **Capacity:** *23* **Residents Served:** *23*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *91*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *34*
Have Physical Disability: *2*

Inspections / Reviews

08/28/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/23/2023*

09/25/2023 - POC Submission

Submitted By [redacted] **Date Submitted:** *11/03/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/02/2023*

10/11/2023 - POC Submission

Submitted By [redacted] **Date Submitted:** *11/03/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/18/2023*

11/21/2023 - Document Submission

Submitted By [redacted] **Date Submitted:** *11/03/2023*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

16c Incident reporting

1. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On 8/5/23 at approximately 6:52 a.m. the local fire department responded to reports that resident #1 was trapped in the residence's East wing left elevator. However, the incident was not reported to the Department's assisted living residence regional office or the Department's assisted living residence complaint hotline until 8/30/23 at 10:55 a.m.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

At the department's request an incident form was completed and submitted on 8/30/23. Moving forward the administrator and or designee will complete a whole house monitoring system of any possible and or confirmed reportable incidents. This form will be completed daily and continue for four weeks. The administrator and or designee will educate all staff on what an reportable incident is and the correct time frame.

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

Implemented [redacted] - 11/21/2023)

17 Record confidentiality

2. Requirements

2800.
17. Confidentiality of Records - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 8/28/23 at approximately 9:02 a.m. four empty medication blister packs were found unlocked, unattended, and accessible on top of the medication cart in the first floor East hallway to the right of the main entrance to the residence to include resident #2's Spironolactone 25mg tablet, resident #3's Vitamin D3 2000u tablets 50mcg, resident #4's Aspirin EC 81mg tablet, and resident #5's Valsartan 320mg tablet.

On 8/28/23 at approximately 9:05 a.m. the nurse's office directly across the hallway from the residence's East wing elevator bank was left unlocked, unattended, and accessible and had protected health information to include an Omnicare pharmacy reorder form with resident #6's Melatonin 5mg tablet, resident #7's Melatonin 3mg tablet, resident #8's Melatonin 5mg tablet, resident #9's Senexon-8 8.6mg-50mg tablet and Enalapril Maleate 20mg tablet, resident #10's Metoprolol Tartrate 25 mg tablet, and resident #11's Losartan Potassium F 25mg tablet, assessment and support plans containing resident names and date's-of-birth for resident #12, resident #13, resident #14, resident #15, resident #16, and resident #17.

On 8/28/23 at 1:33 p.m. there was a binder labeled "East 3 Narcs" sitting on top of the third-floor East wing medication cart that contained protected health information for residents #18's Ultram and resident #17's Ativan. The "East 3 Narcs" binder also contained a "3 East Get up List" that included protected health information for multiple residents to include incontinence needs for resident #19 and resident #1 and a shower schedule for multiple residents for the 7-3 shift that included resident #20, resident #21, resident #22, resident #23, resident #11, resident #24, resident #18, resident #2, resident #25, and resident #26.

17 Record confidentiality *(continued)*

Plan of Correction ***Accept [redacted] 09/25/2023)***

As an immediate action on 8/28/2023, the Administrator instructed clinical staff to remove all PHI from med carts and ensured the nurses office was locked. All staff will be educated no later than 10/3/2023 on keeping protected health information secured. Administrator or designee will audit each nursing station, the nurses office, and the tops of medication carts. These audits will start the week of 9/25/2023 and will be weekly x 3 weeks, then monthly x 3 months.

Licensee's Proposed Overall Completion Date: *10/03/2023* Not Implemented [redacted]-11/21/23)

18 Other laws, regs, ordins.

3. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On 8/28/23 at approximately 2:55 p.m. the carbon monoxide detector in the basement laundry room was located approximately seven feet from each of the residence's six gas powered Unimac commercial laundry dryers. In accordance with the Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/2016, "An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance."

Plan of Correction ***Accept [redacted] - 09/25/2023)***

The CO detector currently installed is hard wired into the facility, by 9/25/23 the residence will install a battery operated CO detector not less than 15 feet away from the commercial laundry dryers. Moving forward administrator or designee will conduct monthly audits of all CO detectors in the facility to ensure they are placed appropriately.

Licensee's Proposed Overall Completion Date: *09/25/2023* Not Implemented [redacted]-11/21/23)

25b Contract signatures and renewal

4. 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 #26's resident-residence agreement dated [redacted]/23 was not signed or dated by the resident.

Resident #27's resident-residence agreement dated [redacted]/23 was not signed or dated by the administrator or a designee and was not signed or dated by the resident.

Plan of Correction ***Accept [redacted] - 09/25/2023)***

The Administrator or designee will ensure the two contracts in question are signed no later than 9/25/23. The facility is now using a program called senior sign for their admission paperwork/contracts. By 10/31/2023 each resident residing in the facility will have a new contract signed through senior sign or have a new contract printed and signed on paper. Moving forward all new admissions will have their contracts signed electronically through senior sign or on paper if they wish.

Licensee's Proposed Overall Completion Date: *10/31/2023* Not Implemented [redacted]-11/21/23)

82c Locked poisons

5. Requirements

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

Description of Violation

On 8/28/23 at approximately 2:00 p.m. there was a one-gallon container that was approximately seven-eighth's full of State Ecolution Hypoallergenic Laundry detergent with poison warning label that indicated "Danger: Causes serious eye damage. Causes mild skin irritations. Precautions: Wear eye protection/face protection. First Aid: If in eyes: Rinse cautiously with water for several minutes. Remove contact lenses if present and easy to do. Continue rinsing. Immediately call a Poison Center or physician. If skin irritation occurs: Get medical attention." All residents of the residence's special care unit, the memory impaired unit (MIU), are assessed as unsafe or unable to use poisonous materials to include resident #8 and resident #28 who reside in the shared resident living unit #[redacted]

Plan of Correction ***Accept [redacted] - 10/11/2023)***

At the time of the inspection on 8/28/23 the laundry detergent was place behind locked doors to prevent residents from having access to the poisonous materials. Moving forward the administrator or designee will conduct an audit of the MIU weekly x6 weeks to ensure locked doors remain locked and the poisonous materials are kept out of the reach of the residents cannot safely avoid them. All staff members were educated by the administrator and designee on the policy and procedures regarding this violation and this was completed on 10/3/23

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

Implemented ([redacted] - 11/21/2023)

85d Trash cans – kitchen/bath

6. Requirements

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 8/28/23 at approximately 2:25 p.m. there was a trash can with no lid in the shared resident bathroom of resident living unit #108 belonging to resident #[redacted] and resident #[redacted] that was three-quarters full of surgical gloves, paper towels, and a mix of white and pink soiled adult briefs.

Plan of Correction ***Accept [redacted] 10/11/2023)***

On 8/29/23 a garbage can with a lid was placed in the residents bathroom. Moving forward the administrator or designee will complete a baseline audit of all resident bathrooms no later than 10/6/23. Administrator or designee will continue to audit a sample of 10 resident bathrooms per week for 4 weeks to ensure compliance. All staff members were educated by the administrator and designee on the policy and procedure regarding this violation. This education was completed on 10/6/23.

Licensee's Proposed Overall Completion Date: *10/10/2023* Not Implemented ([redacted]-11/21/23)

95 Furniture & Equipment

7. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

95 Furniture & Equipment *(continued)*

Description of Violation

On 8/28/23 at approximately 2:20 p.m. the garbage can in the memory impaired unit (MIU) #1 shower room was broken and missing one-half of the lid flaps to create a seal or lid on the garbage can.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

On 8/29/23 a garbage can with a lid was place in the facilities MIU shower room. Moving forward the administrator or designee will complete a baseline audit of all resident shower rooms no later than 10/6/23. The administrator and or designee will continue to audit each shower room for four weeks to ensure furniture and or equipment are all in good working repair. All staff members were educated by the administrator and designee on the policy and procedure regarding this violation. This education was completed on 10/6/23.

Licensee's Proposed Overall Completion Date: *10/10/2023* Not Implemented [redacted]-11/21/23)

141a Medical evaluation

8. 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:

Description of Violation

[redacted] VIOLATION WITHDRAWN 11/21/23 JK

[redacted] VIOLATION WITHDRAWN 11/21/23 JK

[redacted] VIOLATION WITHDRAWN 11/21/23 JK

Resident #32's initial medical evaluation was dated [redacted]23. However, resident #32 was admitted to the assisted living residence on [redacted]/23.

Plan of Correction ***Accept [redacted] - 09/25/2023)***

Each resident listed in this violation is on the list to be seen by a provider. The facility administrator or designee will complete as much of the ADME as allowed and have the provider complete the evaluation and sign off on the ADME. The facility administrator will conduct a whole house audit of all resident ADME to ensure that they are compliant with the requirements. This audit will be completed no later than 10/13/2023. Moving forward the dates for annual ADME will be added to the ASP spreadsheet already created to track when resident forms are coming due.

Licensee's Proposed Overall Completion Date: *10/13/2023* Implemented [redacted]-11/21/23)

183b Medications and syringes locked

9. 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.

183b Medications and syringes locked *(continued)*

Description of Violation

On 8/28/23 at approximately 9:05 a.m. the following medications were unlocked, unattended, and accessible on the desk in the first-floor nurse's office located directly across from the East wing elevator bank:

- *Two bottles of resident #19's Quetiapine Fumarate 50mg tablets*
- *A box of Lidocaine HCL Viscous 20mg/1ml solution that belonged to resident #33*
- *Resident #34's Ezetimibe 10mg tablet*
- *Resident #35's Cerovite Senior 4-300-250 tablet*
- *Resident #36's Pantoprazole Sodium 40mg tablet*
- *Resident #37's Warfarin 7.5mg tablet.*

On 8/28/23 at approximately 1:30 p.m., resident #38, who was assessed as able to self-administer medications, indicated that [redacted] leaves [redacted] medications on the desk in resident living unit #[redacted] of the East wing and leaves the door unlocked. All of resident #38's medications are left unlocked, unattended, and accessible to include Alendronate Sodium 70mg Tablet, Atenolol 50mg Tablet, Calcium 1200 Chewable 1200-1000MG-UNIT Tablet, Centrum Silver Tablet, Hydroxyzine HCl 10mg Tablet, Levothyroxine Sodium 88mcg Tablet, Oxybutynin Chloride ER 10mg Tablet, Pantoprazole Sodium 40mg Tablet, and Acetaminophen 500mg tablet.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

The day of the inspection the clinical coordinator locked the nurses office where the medications in question were stored. DCS and licensed staff are to be educated on the proper storage of medications no later than 10/3/23
**UPDATE----- this was completed by the administrator and designee* however, random audits of nursing office will occur for four weeks starting 10/3/23; this will be completed by the administrator and or designee. Moreover, administrator and designee completed an audit of which residents self-administer medications. Education was also completed on 10/6/23 on safe handling and proper storage of medications. Random audits of residents who self-administer will be completed weekly by administrator and or designee weekly for four weeks.*
The facility does not agree with the second finding of this violation. The resident in question that self-administers medications was in [redacted] room at the time this potential violation was discovered. At no point was it observed that the resident left [redacted] room unattended with the medications unlocked. This violation was only cited based on subjective information obtained through an interview, it was not observed that the resident left [redacted] medications unattended, or room unlocked for any amount of time during this inspection. At this time the facility would like to submit only a plan of correction for the unlocked nurse's office.

Licensee's Proposed Overall Completion Date: *10/10/2023* Not Implemented ([redacted]-11/21/23)

183d Current medications

10. Requirements

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

Description of Violation

On 8/29/23 at approximately 2:15 p.m., a box with Trulicity 3mg/0.5ml injectors belonging to resident #39 was found in the locked refrigerator of the residence's medication room. However, resident #39's Trulicity 3mg/0.5ml weekly dose was discontinued 8/25/23 and replaced with Trulicity 4.5mg/0.5ml, inject 0.5ml (4.5mg) subcutaneous once weekly.

Plan of Correction ***Accept [redacted] 10/11/2023)***

At the time of the inspection, the incorrect dose was disposed of by the clinical coordinator. Upon investigation the correct dose of the medication was in a different medication refrigerator and was moved to the correct refrigerator.

183d Current medications (continued)

Moving forward the administrator and or designee will audit all the medication refrigerators weekly for four weeks to ensure all medications are current and match the EMAR. Audits will be completed by the administrator and or designee. All staff were reeducated on the importance of removing and expired medications or non-current. This education was completed by the administrator and designee.

Licensee's Proposed Overall Completion Date: *10/10/2023* Not Implemented [redacted]-11/21/23)

183e Storing Medications

11. Requirements

2800.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 8/29/23 a bottle of Latanoprost 0.005% eye drops for resident #40 was labeled, "Refrigerate until open, then store at room temperature and discard after six weeks." However, resident #40's Latanoprost 0.0005% drops indicated the date opened was 6/21/23.

Plan of Correction ***Accept [redacted]- 09/25/2023)***

At the time of inspection, this medication was removed from the medication cart. Moving forward, the Administrator or designee will provide education to direct care staff regarding removing expired medications/proper storage in the medication carts no later than 10/3/2023. After education is completed, the administrator or designee will continue audits of the med carts from previous plan of correction regarding a similar situation. Audits will run weekly until 10/27/2023 to ensure proper storage of medications.

Licensee's Proposed Overall Completion Date: *10/03/2023* Not Implemented [redacted]-11/21/23)

184a Resident meds labeled

12. Requirements

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

Description of Violation

The pharmacy label for resident #39's Basaglar KWIK INJ 100UNIT/ML indicated, inject 30 units subcutaneously once daily. However, resident #39 was prescribed two separate orders for Basaglar KWIK INJ 100UNIT/ML, the first order was "Inject 30 units subcutaneously every morning" and the second order was "Inject 20 units subcutaneously every day at bedtime" and there was no separate Kwik-pen with the correct label for the second order.

The pharmacy label for resident #28's Acetaminophen ER 650mg indicated, 1 tab by mouth every 8 hours as needed." However, resident #28 is prescribed Acetaminophen ER 650mg, give one tablet by mouth every 6 hours as needed.

The pharmacy for resident #4's Novolog Flexpen 100UNITS/ML indicated: Inject SQ three times daily before meals for blood sugar if 90-119=13 units 120-150=14 units 151-200=15 units 201-250=16 units 251-300=17 units, 301-350=18 units 351-400=19 units 401-450=20 units 451-500=21 units; Inject SQ three times daily after meals if 70-89=2 units. However, the pharmacy label did not include additional orders to inject 2 units of Novolog subcutaneously three times daily before meals (give when blood sugar is over 300).

184a Resident meds labeled *(continued)*

Plan of Correction ***Accept [redacted] - 09/25/2023)***

The facility has stickers to indicate a change of direction on a pharmacy label when an order changes. On 9/12/23 the administrator provided education to all licensed staff regarding placing change of direction stickers on medications that have had an order change. Moving forward the administrator or designee will continue to conduct weekly audits of five random resident's medications to ensure the pharmacy label matches the physician order/emar. The medications listed in this violation will be added to next week's audits and will have stickers placed on any order that has changed no later than 9/25/23.

Licensee's Proposed Overall Completion Date: *09/25/2023* Not Implemented [redacted]-11/21/23)

185a Storage procedures

13. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

During the month of August 2023, resident #4's medication administration record (MAR) had multiple incorrect and missing blood glucose readings from the resident's glucometer to include:
· 8/9/23 at 4:30 p.m. Glucometer reading: 230 mg/dL MAR: 220 mg/dL
· 8/18/23 at 4:12 p.m Glucometer reading: 196 mg/dL MAR: 198 mg/dL
· 8/21/23 at 7:49 a.m Glucometer reading: 260 mg/dL MAR: 262 mg/dL
· 8/26/23 at 7:03 a.m. Glucometer reading: 184 mg/dL MAR: 198 mg/dL
· 8/27/23 at 6:54 p.m. Glucometer reading: 210 mg/dL MAR: Not documented
· 8/28/23 at 6:26 p.m. Glucometer reading: 226 mg/dL MAR: Not documented
· 8/29/23 at 6:55 p.m. Glucometer reading: 246 mg/dL MAR: Not documented

During the month of August 2023, resident #12's MAR had multiple incorrect and missing blood glucose readings from resident #12's glucometer to include:
· 8/18/23 at 9:21 a.m. Glucometer reading: 162 mg/dL MAR: Not documented
· 8/20/23 at 4:40 a.m. Glucometer reading: 169 mg/dL MAR: Not documented
· 8/21/23 at 8:44 a.m. Glucometer reading: No reading MAR: 194 mg/dL
· 8/22/23 at 3:23 a.m. Glucometer reading: 195 MAR: Not documented
· 8/23/23 at 9:29 a.m. Glucometer reading: No reading MAR: 201

During the month of August 2023, resident #39's MAR had multiple incorrect and missing blood glucose readings that were not taken on the resident's glucometer to include:
· 8/16/23 at 8:02 p.m. Glucometer reading: 323 mg/dL MAR: 328 mg/dL
· 8/17/23 at 8:25 p.m. Glucometer reading: 324 mg/dL MAR: 325 mg/dL
· 8/22/23 at 9:00 p.m. Glucometer reading: No reading MAR: 340 mg/dL
· 8/23/23 at 8:10 p.m. Glucometer reading: 363 mg/dL MAR: 383 mg/dL
· 8/25/23 at 8:29 p.m. Glucometer reading: 340 mg/dL MAR: 360 mg/dL

Resident #41 is prescribed a hospice "E-kit" which included Morphine concentrate 100mg/5mg 0.5 subcutaneously every 2 hours as needed, Haloperidol 2mg/ml 0.5ml subQ every subcutaneously every 4 hours as needed, Guafenesin 100mg/5ml 10ml subcutaneously every 4 hours as needed, Atropine 1% drops give 2 drops every hour as needed,

185a Storage procedures (continued)

and Lorazepam 2mg/ml 0.5ml sublingually every four hours as needed. However, resident #41's E-Kit expired, was not replaced, and on 8/29/23 none of the medications were on the cart or in the residence to administer if requested or needed by resident #41.

Resident #12's glucometer is not set to the correct time. On 8/30/23 at 12:30 p.m. the glucometer indicated a date of 8/30/23 and a time of 10:43 a.m.

Plan of Correction ***Directed [redacted] - 10/11/2023)***

At this time, facility glucometers will be audited by 9/25/23 to ensure they have the correct date and time. Moving forward the administrator and or designee will move this audit into the already scheduled running med cart audits for PRN medications and extend this audit for an additional three weeks. These audits will run till 10/27/23. The audit will include ensuring the Date, Time, and Reading are all correct. The readings will be compared to the EMAR to ensure accuracy. This audit will be completed by the Administrator and or designee.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall contact resident#41's hospice agency and have the E-kit replaced. [redacted]10/11/23

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall conduct a biweekly audit of all MARs, resident prescriptions, and medications to ensure all prescribed are in the home for administration, and not expired or discontinued. [redacted]10/11/23

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons qualified to administer medications on the homes policies and procedures for measuring blood glucose readings, and the documentation of blood glucose readings. Documentation of education shall be kept.[redacted]10/11/23

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons qualified to administer medications on the homes policies and procedures for managing and calibrating glucometers to ensure the correct dates and times. Documentation of education shall be kept.[redacted] 10/11/23

Directed Completion Date: *10/15/2023* Not Implemented [redacted]-11/21/23)

190c Record of training

14. Requirements

2800.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Direct care staff person A's medication administration training documentation was incomplete and did not include the direct care staff person's score on the multiple choice exam or the four skills for handwashing and gloving.

Plan of Correction ***Accept [redacted] - 09/25/2023)***

By 9/25/23 the staff member in question will have their medication administration training documentation amended to include the exam score as well as the handwashing competency. Moving forward the administrator or designee will audit all medication administration documentation weekly x 4 weeks to ensure all med techs have the correct documentation in place to pass medications.

Licensee's Proposed Overall Completion Date: *09/25/2023* Not Implemented [redacted]-11/21/23)

224a2 30 days prior to admission

15. Requirements

2800.
224.a.2. An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

Description of Violation

Resident #31, admitted [redacted]/23, did not have an initial assessment.

Resident #32, admitted [redacted]/23, did not have an initial assessment.

Plan of Correction ***Accept [redacted] 10/11/2023)***

Administrator and or designee will complete a whole house audit of admissions from 7/1/23 to current to ensure that all residents have had their initial assessment and support plan completed. This audit was completed on 8/30/23. Any resident that did not have an assessment and or support plan will have one completed no later than 9/12/23. Additional audits will begin the week on 9/4/23; this will take place weekly by the administrator and or designee weekly to ensure nothing has been missed. Administrator and or designee will complete a spread sheet of all residents to track initial, quarterly, and annual for each resident to ensure proper tracking. Additionally the ASP, and ADME were completed for both residents in question on 10/5/23 by the administrator.

Licensee's Proposed Overall Completion Date: *10/10/2023* Not Implemented [redacted]-11/21/23)

224c1 Initial SP-30 days prior/adm

16. Requirements

2800.
224.c.1. An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

Description of Violation

Resident #31, admitted [redacted]/23, did not have a written preliminary support plan developed within 30 days prior to admission to the residence.

Resident #32, admitted [redacted]/23, did not have a written preliminary support plan developed within 30 days prior to admission to the residence.

Plan of Correction ***Accept [redacted] 10/11/2023)***

Administrator and or designee will complete a whole house audit of admissions from 7/1/23 to current to ensure that all residents have had their initial assessment and support plan completed. This audit was completed on 8/30/23. Any resident that did not have an assessment and or support plan will have one completed no later than 9/12/23. Additional audits will begin the week on 9/4/23; this will take place weekly by the administrator and or designee weekly to ensure nothing has been missed. Administrator and or designee will complete a spread sheet of all residents to track initial, quarterly, and annual for each resident to ensure proper tracking. Additionally the ASP, and ADME were completed for both residents in question on 10/5/23 by the administrator.

Licensee's Proposed Overall Completion Date: *10/10/2023* Not Implemented [redacted]-11/21/23)

227a Final support plan – 30 days

17. Requirements

2800.

227a Final support plan – 30 days *(continued)*

227.a. Each resident requiring services shall have a written final support plan developed and implemented within 30 days after admission to the residence. The final support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #26, admitted [redacted]23, did not have a final support plan documented on the Department's support plan form within thirty days after admission to the residence.

Resident #27, admitted [redacted]23, did not have a final support plan documented on the Department's support plan form within thirty days after admission to the residence.

Resident #31, admitted [redacted]23, did not have a final support plan documented on the Department's support plan form within thirty days after admission to the residence.

Plan of Correction ***Accept ([redacted]- 10/11/2023)***

Administrator and or designee will complete a whole house audit of admissions from 7/1/23 to current to ensure that all residents have had their initial assessment and support plan completed. This audit was completed on 8/30/23. Any resident that did not have an assessment and or support plan will have one completed no later than 9/12/23. Additional audits will begin the week on 9/4/23; this will take place weekly by the administrator and or designee weekly to ensure nothing has been missed. Administrator and or designee will complete a spread sheet of all residents to track initial, quarterly, and annual for each resident to ensure proper tracking. Additionally the ASP, and ADME were completed for both residents in question on 10/5/23 by the administrator.

Licensee's Proposed Overall Completion Date: *10/10/2023* Not Implemented([redacted]-11/21/23)

231d No objection statement

18. Requirements

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

Description of Violation

There was no documentation in resident #28's record that the resident, the resident's designated person, or the resident's family agreed to the resident's admission to the facility's special care unit.

There was no documentation in resident #42's record that the resident, the resident's designated person, or the resident's family agreed to the resident's admission to the facility's special care unit.

Plan of Correction ***Accept([redacted]- 10/11/2023)***

No later than 10/6/23 the facility will ensure all the residents that are located in the MIU have a signed no objection statement in their resident record. Administrator and or designee will provide all necessary documentation and add this objection statement to the admission packet. Administrator and designee completed the necessary paperwork with the families of the residents in question on 10/6/23

Licensee's Proposed Overall Completion Date: *10/10/2023* Not Implemented([redacted]-11/21/23)

232d Awareness/independence

19. Requirements

2800.

232d Awareness/independence *(continued)*

232.d. The residence shall provide a full description of the measures implemented to enhance environmental awareness, minimize environmental stimulation and maximize independence of the residents in public and private spaces based on the needs of the individuals being served.

Description of Violation

The residence did not have a written description of the measures implemented to enhance environmental awareness, minimize environmental stimulation, and maximize independence of the residents in public and private spaces based on the needs of the individuals being served in the residence's special care unit, the memory impaired unit (MIU).

Plan of Correction ***Accept [redacted] - 09/25/2023)***

No later than 10/6/2023 the facility will ensure that there is a written description of the measures implemented to enhance environmental awareness, minimize environmental stimulation, and maximize independence of the residents in public and private spaces based on the needs of the individuals being served in the residence's special care unit, the memory impaired unit (MIU). The facility does have a description as it was required for the transition to take place from one owner to another on 7/1/2023. Moving forward the administrator or designee will create a new written description if the current one cannot be provided.

Licensee's Proposed Overall Completion Date: *10/06/2023* Not Implemented [redacted]-11/21/23)

252 Records – content

20. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

The resident record for resident #26 did not include the following information:

(2) Height, weight at time of admission, color of hair, color of eyes
(3) A photograph of the resident that is no more than two years old
(18) An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.

The resident record for resident #27 did not include the following information:

(2) Height, weight at time of admission, color of hair, color of eyes
(3) A photograph of the resident that is no more than two years old
(18) An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.

The resident record for resident #31 did not include a photograph of the resident that was no more than two years old.

The resident record for resident #32 did not include the height of the resident or a photograph of the resident that was no more than two years old.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

Facility administrator and or designee are currently working to update all demographics that were not pulled from

252 Records – content (continued)

the previous computer system prior to Change of ownership. The administrator and or designee will have all demographics entered into the system no later than 10/31/23 but will have the ones completed for residents cited completed earlier by 10/15/23. Once all basic demographics are entered the administrator and or designee will audit 15 resident profiles weekly for four weeks to ensure the facility remains compliant. These audits will begin on 11/6/23.

Licensee's Proposed Overall Completion Date: *10/31/2023*

Not Implemented [redacted]-11/21/23)

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

Facility Information

Name: *THE VILLAGES OF HARMAR* **License #:** *45456* **License Expiration:** *07/01/2024*

Address: *715 FREEPORT ROAD, CHESWICK, PA 15024*

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

Administrator

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

Legal Entity

Name: *THE VILLAGES OF HARMAR, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/24/2006* **Issued By:** *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *128* **Waking Staff:** *96*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *09/28/2023*

Inspection Dates and Department Representative

09/26/2023 - On-Site: [redacted]
09/27/2023 - On-Site: [redacted]
09/28/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *133* **Residents Served:** *97*

Special Care Unit

In Home: *Yes* **Area:** *Elms 1st floor* **Capacity:** *21* **Residents Served:** *21*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *97*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *31* **Have Physical Disability:** *0*

Inspections / Reviews

09/26/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/07/2023*

11/07/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/21/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/17/2023*

11/16/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/21/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/22/2023*

11/21/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/21/2023*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

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 Violation

On 9/26/23 at 9:00 a.m. there were the following resident documents unlocked, unattended, and accessible as follows:
• The top right corner of the front desk there was a Grane Hospice binder that contained numerous invoices for medications, equipment, and so on for multiple residents to include: a packing slip dated 9/25/23 packing slip with multiple resident's names and medications including, residents #1, #2, #3, #4, and #5. At 11:50 a.m., the binder was still on the counter of the front desk.

• The door to the LPN's office is to the left of the front desk was unlocked and unattended from approximately 9:00 a.m. to 9:10 a.m. There were multiple resident records/documents accessible on the desk, and in boxes throughout multiple areas of the room, to include:
o A large dry erase board hanging on the wall with resident names and confidential information visible from the hall.
o A large box on floor next to the clear trash bag containing multiple resident Medication Administration Records and Narcotic count sheets for August and September 2023.

On 9/26/23 at approximately 3:30 p.m., the third-floor North wing nurses' station, there was an unlocked, unattended, and accessible staff communication log and 3 pages of a packing slips, dated 9/25/23 indicating resident names and medication lists, to include resident #9 and #10.

On 9/27/23, at approximately 2:35 p.m., the East 1 Narc Binder was unlocked, unattended, and accessible on top of the med cart on the first floor East Wing, that identified narcotics prescribed for the following residents, to include: resident #7 and #8.

Plan of Correction ***Directed [redacted] - 11/16/2023)***

2800.17—Confidentiality of Records
Through prior violations and or inspections whole house education on proper storage of all records was completed on OCT 18, 2023. This education included the nurses office staying closed and or locked when unattended, ensuring all nurses' stations have no resident information visible or accessible, and finally ensuring that the Narc book is kept inside of the Med Cart when not in use. Administrator and or designee will continue these audits starting on 11/20/2023. These audits will include all of these areas listed above and will be completed by various management staff including, Administrator, LPNS or Clinical Coordinators. Once these Audits start they will continue for four more weeks, then after four weeks the audits will go to monthly then to every three months.

Proposed Overall Completion Date: 12/18/2023

DIRECTED
Within 5 calendar days of the receipt of the accepted plan of correction: The administrator shall educate staff persons on Regulation 2800.17 and the home's policy and procedures for maintaining resident records in a secure location. Documentation of education shall be kept in accordance with Regulation 2800.65(l). 11/16/23 [redacted]

17 Record confidentiality *(continued)*

Directed Completion Date: *11/21/2023* Not Implemented [redacted]-11/21/23)

25a Resident - residence contract

2. Requirements

2800.
25.a. Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #11 was admitted to the home on [redacted]/22; however, on [redacted]/23, there was no Resident-residence contract in the resident's record. The home was unable to provide one and interviews with the family reported they were never provided a contract.

Plan of Correction ***Directed [redacted]- 11/16/2023)***

2800.25a--- Resident—Residence Contract
Through prior violations and or inspections whole house audits were completed throughout the month of October. Through these Audits the Administrator and or designee have held contract signing days to ensure all residents have a current Saber Contract Signed. Staff including, all direct care staff, LPNS, Clinical Coordinators, the importance of having the current and new residents sign contracts from Saber. Management staff will be the only ones responsible for having new and current contracts signed. However, this resident in particular has discharged therefore no contract has been signed. Moving forward, administrator and or designee will ensure the new admission timeline and checklist is completed timely and accurate.

Proposed Overall Completion Date: 12/18/2023

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete a contract for resident #11. 11/16/23

Directed Completion Date: *11/17/2023* Not Implemented [redacted]-11/21/23)

41e Signed statement

3. Requirements

2800.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

On 9/28/23, resident 11's record did not include a statement signed by the resident and the resident's designated person acknowledging of being informed of resident rights and the right to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the reporter. Retaliation includes discharge or transfer from the residence.

Plan of Correction ***Directed [redacted]- 11/16/2023)***

2800.41e--- Requirements Signed Statements

41e Signed statement (continued)

Through prior violations and or inspections whole house audits were completed throughout the month of October. Through these Audits the Administrator and or designee have held contract signing days to ensure all residents have a current Saber Contract Signed. Staff including, all direct care staff, LPNS, Clinical Coordinators, the importance of having the current and new residents sign contracts from Saber. Management staff will be the only ones responsible for having new and current contracts signed. However, Located in the contract there is specific verbiage and information on Resident Rights, how to lodge complaints, and so on. Moreover, this resident in particular has discharged therefore no contract has been signed. Moving forward, administrator and or designee will ensure the new admission timeline and checklist is completed timely and accurate.

Proposed Overall Completion Date: 12/18/2023

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall obtain a statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature 11/16/23 [redacted]

Directed Completion Date: *11/17/2023* Not Implemented [redacted]-11/21/23)

42e Telephone access

4. Requirements

2800.
42.e. A resident shall have access to a telephone in the residence to make calls in privacy. Non toll calls shall be without charge to the resident.

Description of Violation

On 9/26/23, interviews indicated when calling the residence [redacted] *the telephone service was inoperable in August and then September 1, 2023, through September 28, 2023. Interviews including the family of resident #11, reported calling the residence nursing line for the LPN on duty to discuss medical concerns, that would just ring with no way to leave a message. The family was told after so many rings it was to automatically switch to the front desk; however, there is usually no one at the front desk. If by chance, there is someone at the front desk interviews indicate they don't know how to transfer or who to transfer the calls to.*

Plan of Correction ***Accept*** [redacted] ***- 11/16/2023)***

2800.42e--- Requirements Telephone Access
Through prior violations and inspections whole house education was completed in the months August, September, and October. Administrator and or designee have informed staff of the proper policy and procedures in regards to what happens when a telephone outage occurs, this includes allowing residents to make calls using staff member's personal phones. Administrator, and or designee have completed a written informational sheet and it was given to all residents on what to do when there is a telephone outage. Also, the facility now has an all call cell phone that can be answered 24.7 by a management team member that includes, Administrator, Clinical Coordinator, and LPNS. This number is posted throughout the building for all residents, staff, and family members can see and use. Moving forward Administrator and designee have made an audit which has started on 11/1/23 where random calls are made throughout the day and night to ensure the phones are in working order. This audit will be completed once a week for six weeks, then move to monthly for three months. Also, due to the continued problems the facility did have an entire new modem installed.

42e Telephone access (continued)

Licensee's Proposed Overall Completion Date: Not Implemented [redacted]-11/21/23)

85a Sanitary conditions

5. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9/26/23,9/27/23 and 9/28/23, between 9:00 a.m. and 5:00 p.m., there was a very strong odor of urine present at front desk and hallway by living unit #134 in the East wing. The odor of urine appeared to be coming from the living unit #134 on the first floor where resident #[redacted] resides.

Plan of Correction ***Directed [redacted] 11/16/2023)***

2800.85a--- Sanitary conditions
Administrator and or designee have worked with housekeeping to ensure that all sanitary conditions are met. Especially odor, we have put out new scent diffusers, also clean the room more often. Administrator and or designee will work with housekeeping to complete weekly audit sheet of when the room is cleaned. This audit will start on 11/20/2023 and will continue for three months and or until the carpet is replaced whichever is sooner. Facility will also insure that daily environmental rounds which will begin the week of 11/20/23 Administrator and or designee will pick seven (7) random rooms and inspect them for any smells, debris, or anything else that may be out of order. Within the next couple of months the carpet will be replaced as well.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on Regulation 2800.85(a) and the home's policy and procedures for correcting or reporting unsanitary conditions. Documentation of education shall be kept in accordance with Regulation 2800.65(l). 11/16/23[redacted]

Directed Completion Date: *11/21/2023* Not Implemented [redacted]-11/21/23)

101d2 Kitchen – old construction

6. Requirements

2800.
101.d.2. Kitchen capacity requirements are as follows: Existing facilities. Facilities that convert to residences after January 18, 2011, must meet the following requirements related to kitchen capacity:
i. The residence shall provide space with electrical outlets suitable for small appliances, such as a microwave oven and small refrigerator.
A. Upon entering the assisted living residence, the resident or his designated person shall be asked if the resident wishes to have a cooking appliance or small refrigerator, or both. The cooking appliance or small refrigerator, or both, shall be provided by the residence if desired by the resident or his designated person. If the resident or his designated person wishes to provide his own cooking appliance or small refrigerator, or both, it must meet the residence's safety standards.

Description of Violation

On 9/26/23, at approximately 1:45 p.m. resident #4's living unit #[redacted] on first floor of North Wing is a large suite. There are ample electrical outlets for use of small appliances; however, there is no small kitchenette with counter space provided for cooking or any type of cabinet for food storage. Interviews indicated resident #4 purchased an electric griddle; however, there is no counter space to place the griddle on to cook that meets the residence's safety standards.

101d2 Kitchen – old construction (continued)

Interviews indicated the resident had placed the griddle on top of cardboard boxes and cooked on it, where it was very cluttered posing a fire hazard.

Plan of Correction ***Directed [redacted]- 11/16/2023)***

2800.101d.2--- Kitchen-- Old Construction
*All residents have the option to have fridge and or microwave in their rooms if they so choose. Administrator has made a new audit sheet to be included with the Admission Contract that allows each resident to choose if they would like either or. This sheet also includes if they would like phone, or laundry services at an additional cost. *In the Memory Impairment Unit everything is considered all inclusive. ** Administrator and or Designee will complete this audit for all current residents and will have this completed by no later than 11/13/23. However, in particular small appliances are only allowed in resident rooms if they are appropriate. Maintenance must inspect all small appliances to ensure there is no fire hazard. For resident Number four in particular,[redacted]hot plate was removed due to unsafe conditions. Administrator and or designee have made an audit sheet for all resident rooms to be inspected weekly to ensure there are no non approved small appliances. The baseline Audit will be completed no later than 11/23/23, and then the audit will continue weekly for four weeks, then move to monthly for an additional three months. All direct care staff were educated on fire hazards, and what is and is not allowed in resident rooms.*

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons responsible implement Regulation 2800.102(d)(2) and the home's policy and procedures regarding the regulation. Documentation of education shall be kept in accordance with Regulation 2800.65(l). 11/16/23 [redacted]

Directed Completion Date: *11/21/2023* Not Implemented [redacted]-11/21/23)

101n Walls, floors & ceilings

7. Requirements

2800.
101.n. The living unit must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 9/26/23, the carpet in resident # [redacted] *living unit, #336 on the third floor/East Wing, in in disrepair. The thread has been pulled from the carpet backing measuring approximately 3' from the wing back chair by the window running under the resident's bed.*

Plan of Correction ***Directed [redacted] 11/16/2023)***

2800.101n--- Walls, Floors, Ceilings
In order to meet the regulation requirements in this section Administrator and or Designee will create an audit to ensure all the carpets, walls, and ceilings are in good repair. For this particular violation the carpet strand was removed immediately. Facility will complete a baseline audit of all resident rooms the week of 11/13/23 to be completed by management staff. Facility will also insure that daily environmental rounds which will begin the week of 11/20/23 Administrator and or designee will pick seven (7) random rooms and inspect them for any smells, debris, or anything else that may be out of order.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on Regulation 2800.101(n) and the home's policy and procedures for correcting or reporting walls, floors and

101n Walls, floors & ceilings (continued)

ceilings, which are not finished, unsanitary and in poor repair. Documentation of education shall be kept in accordance with Regulation 2800.65(l). 11/16/23 [redacted]

Directed Completion Date: *11/21/2023* Not Implemented [redacted]-11/21/23)

105f Clothing laundering

8. Requirements

2800.
105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

On 9/27/23 and 9/28/23, multiple resident interviews were conducted indicating the turnaround time for the residents to get laundry back ranged from 2 days up to 5 days and report often have missing clothing or get other residents clothing.

Plan of Correction ***Accept*** [redacted] ***- 11/16/2023)***

2800.105f--- Clothing Laundering
Through previous inspections and or violations Administrator and or Designee have already spoken to housekeeping manager in regards to this violation. Administrator and or designee have spoken to all direct care staff, and housekeeping and laundry to ensure staff are aware that laundry needs to be returned with a reasonable time 24-48 hours depending on the day and if it is a holiday. Housekeeping Manager and Administrator and or Designee will create an audit sheet where seven (7) random residents are asked weekly if they sent out their laundry and if they received all items back in a timely matter and or if something was missing. This audit will begin the week of 11/20/23 and will continue for four weeks and then move to monthly audits for three additional months.

Licensee's Proposed Overall Completion Date: Not Implemented [redacted]-11/21/23)

141b2 Medical evaluation changes

9. Requirements

2800.
141.b. A resident shall have a medical evaluation:
2. If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #4's medical evaluation (ADME) indicates Date of In-Person Evaluation and Date ADME Completed of 9/18/23 for a status change. However, the medical evaluation does not include the date of the TB skin test or chest x-ray, nor does it indicate if a new test is required. The sections are blank. The medical evaluation is not signed by a medical professional and the entire section under the Medical Professional Certification is blank.

Plan of Correction ***Directed*** [redacted] ***- 11/16/2023)***

2800.141.b--- Medical Evaluation Changes
Through previous inspections and or violations Administrator and or Designee have already completed whole house audits for ADME's and ASPS. Any resident that was out of date or close to has had a new ADME or ASP completed in the month of October. For this resident in particular the Clinical Coordinator completed a new ADME and ASP. Through prior violations a month calendar was created to show when all residents are due for an ADME or an ASP. Management Staff will check weekly starting 11/20/23 to ensure there is no ADME or ASP due that week. This audit will continue for four weeks then move to monthly for three months, this audit will be completed by administrator

141b2 Medical evaluation changes (continued)

or designee.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall have resident #4's medical evaluation documentation corrected or have a new min-person medical evaluation completed and documented. 11/16/23

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all current and newly completed medical evaluation documentation for accuracy and completeness. 11/16/23

Directed Completion Date: *11/17/2023* Not Implemented -11/21/23)

162c Menus - posted

10. Requirements

2800.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 9/26/23, at approximately 11:50 a.m., the only menus posted throughout the home indicated "Week of September 24,2023. However, the future week menu was not posted anywhere in the home.

Plan of Correction ***Accept - 11/16/2023)***

2800.162c--- Menus posted
Through prior investigations of not having two weeks of menus posted. Administrator and or designee along with the dietary manager held various meetings that included direct care staff, management, and dietary members in October to explain the regulation. At all times two weeks of menus must be posted in various areas of the facility so all residents can see. Also, if there is a menu change all residents must be informed of this change. The facility has created a new board in the main hallway that holds up to four weeks of menus at a time. Administrator and or designee have created a weekly audit sheet that will begin 11/20/23 to ensure there is two weeks at a minimum posted at all times.

Licensee's Proposed Overall Completion Date: 11/17/2023 Not Implemented -11/21/23)

181c Self-Administer Assessment

11. Requirements

2800.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #4's medical evaluation, dated /23 and initial support plan, /22, both indicated the resident is unable to self-administer medications. However, on 9/27/23 at approximately 1:45p.m., the resident's room had several bottles of OTC medications throughout the room. There were approximately 12 loose assorted medications on a paper plate on a card table and an unopened individual packet from a roll pack indicating," 5/25/23 21:00 Nortriptyline 25mg -one cap one-time daily bedtime." Interviews also indicated staff often take the medications to the resident;

181c Self-Administer Assessment (continued)

however, do not observe the resident taking them and leaves medication in med cups.

Resident #11's medical evaluation, dated [redacted]23 and assessment and support plan (ASP) dated [redacted]/23, indicated the resident is unable to self-administer medications. Direct care staff person E sometime between 9:30 a.m. and 11:20 a.m. put the medications in a med cup and in the resident's living unit #[redacted] on the kitchenette counter. The resident [redacted] returned to residence at approximately 11:24 a.m. The [redacted] reported being met by direct care staff person E, at the elevator who whispered to resident #11, "Your meds are upstairs on the counter."

Plan of Correction ***Directed [redacted]- 11/16/2023)***

2800.181.c--- Self Administer Assessment
Through previous inspections and or violations Administrator and or designee have already completed whole house audit in October and completed assessments and educations on the residents who self-administers and who possibly can. Previously we had two residents able to self-administer this has now changed to one resident. Whole house that included direct care staff and or management staff education was completed on multiple occasions that staff are not to leave medication in resident rooms unattended. Administrator and or designee will do random audits weekly for one month of seven (7) resident rooms to ensure there is no medication left unattended. Then these audits will continue monthly for 3 additional months; all audits will be completed by the administrator and or designee.

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall reassess any resident who is self-administering medication to ensure the resident is capable of self-administering medications. Documentation of assessments shall be kept. 11/16/23[redacted]

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons involved in medication administration on the requirements of regulation 2800.181(c) and the home's policy and procedures for residents who self-administer medications. Documentation of education shall be kept in accordance with Regulation 2800.65(l). 11/16/23[redacted]

Directed Completion Date: *11/21/2023* Not Implemented[redacted]-11/21/23)

183b Medications and syringes locked

12. Requirements

2800.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's living unit.

Description of Violation

The door to the LPN's office is to the left of the front desk was unlocked and unattended from approximately 9:00 a.m. to 9:10 a.m. There were multiple resident records/documents accessible on the desk, and in boxes throughout multiple areas of the room, to include:
- There were multiple large bags and boxes full of hundreds of medications in blister packs and bottles, and roll packs throughout the room of current residents and residents no longer in the home, to include:
** A large clear trash bag more than half full of resident medications as follows:*
Donepezil HCL 5mg prescribed for resident #1.
Levothyroxine 88mg prescribed for resident #4.
Acetamin 325mg prescribed for resident #5.
** There were four red bags stacked on top of each other in back left corner full of medications and three boxes full of medications.*

183b Medications and syringes locked (continued)

Atenolol 25mg and Amlodipine 5mg prescribed for resident #6.
Loratadine 10mg prescribed for resident #7.
Venlafaxine HCL ER 37.5mg prescribed for resident #8.

On 9/27/23, at approximately 1:45 p.m., in the living unit of #[redacted] in North Hall, there were multiple loose medications, approximately 12, on a paper plate on a card table and an individual packet from a roll pack, dated 5/25/23 21:00, Nortriptyline 21mg, as well as several bottles of OTC medications throughout the room, that were unlocked, accessible and unattended. Resident #4 reports never locking the door to living unit #[redacted] when leaving the room or the residence, often gone for days.

On 9/28/23, interviews indicated on 9/25/23, at approximately 9:30 a.m., resident #11 [redacted] left the residence and reported did not secure/lock the living unit #[redacted] prior to leaving. Interviews indicated that direct care staff person E, put the residents 9:00 a.m., morning medications in a med cup and left them on the kitchenette counter in the resident's living unit #[redacted] The following medications were unlocked, unattended and accessible, to include:
Allopurinol tablet, 100mg take one tablet every day (9:00 a.m.).
Doxycycline hyclate tablet, 100mg- take one tablet twice daily (8:00 a.m. & 4:00 p.m.).
Finasteride tablet, 5mg
Pantoprazole tablet, 40mg delayed release
Metoprolol tartrate tab, 25mg
Tamsulosin capsule, 0.4mg

Plan of Correction ***Directed [redacted] 11/16/2023)***

2800.183b--- Medications and Syringes locked
Through previous inspections and or violations Administrator and or designee have already completed whole house audits to ensure there is no medications and or treatments in resident rooms this was done in October. This audit will continue weekly of seven (7) residents weekly for one month then monthly for three additional months to be completed by administrator and or designee. This audit will begin week of 11/20/23. Also, all medications that were found in clear trash bags, red bags, or boxes have been properly disposed of by licensed staff. Moving forward administrator and or designee will ensure that meds are destroyed promptly and correctly.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall ensure the unlocked, unattended, and accessible medications in the North Hall and resident #11 room have been secured. 11/16/23

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons involved in medication administration on the requirements of regulation 2800.183(b) and the home's policy and procedures for the safe storage of medications. Documentation of education shall be kept in accordance with Regulation 2800.65(l). 11/16/23 JK

Directed Completion Date: *11/21/2023* Not Implemented [redacted]-11/21/23)

183e Storing Medications

13. Requirements

2800.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

183e Storing Medications *(continued)*

Description of Violation

Resident #1 is prescribed Lorazepam 2mg/ML, - Give 0.5mg (0.25ml) by mouth every 4 hours as needed. 20 count prefilled syringes. Red sticker on bag indicated "REFRIGERATE". The medication was delivered on 9/23/23. On 9/26/23, at approximately 3:10 p.m., the medication was stored in the narcotic box inside the medication cart that is not refrigerated. Interviews indicated the medication had not been refrigerated since received.

Plan of Correction ***Accept*** [redacted] ***11/16/2023)***

2800.183e--- Storing Medications
Through previous inspections and or violations Administrator and or designee have already completed initial whole house audits on refrigerated medications in the month of October. The administrator and or designee have held multiple whole house education that included, direct care staff, and management staff to ensure that all med techs, and or management staff. The facility did not find any additional medications that were stored incorrectly. However, moving forward administrator, and or designee will perform weekly audits starting week of 11/20/23 to ensure there is no medications stored improperly. These audits will be for four weeks then move to monthly times three months, which will also be completed by Administrator and or designee.

Proposed Overall Completion Date: 12/4/2023

Licensee's Proposed Overall Completion Date: *11/21/2023* Not Implemented [redacted] -11/21/23)

[redacted]

VIOLATION WITHDRAWN 11/21/23 JK

[redacted]

[redacted]

185a Storage procedures

15. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The residence's medication policy for the accountability of controlled substances indicated, "The facility will maintain a readily available record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records will be maintained with the resident's record and in such a manner to allow accurate reconciliation."

On 8/27/23 the residence identified 10 oxycodone were unaccounted for around 8/27/23 in Elm and on North Hall.

Direct care staff person C reported working midnight on Monday 9/18/23 to Tuesday, 9/19/23 until 7:30 a.m. on North-1 Hall At approximately 12:00 a.m. on 9/19/23, direct care staff person C, stated pulled out the blister card of Oxycodone 5 mg to administer to resident #1. The back of the blister pack had been altered and a pill looked like the Oxycodone fell out the side. The medication was identified as Zofran 4mg.

On 9/22/23, a narcotic count was being conducted at 3:00 p.m., by direct care staff person A leaving the shift and direct care staff person B coming on the 3:00 p.m. shift. At approximately 12:00 a.m. on 9/19/23, direct care staff person B picked up the blister pack of Oxycodone 5mg prescribed for resident #1 and noticed a pill in the blister pack that was later identified as Zofran tablet 4mg.

On 9/26/23, resident #1 prescribed Oxycodone 5mg tablets. Take one tablet by mouth four times daily (12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m.) The order was filled 9/25/23. On 9/26/23, review of the resident's September 2023 MAR and Controlled Drug Accountability (Receipt) Record/Disposition Form indicated a count of 25 remaining of 56. However, there was a count of 28 tablets of Oxycodone available in the blister pack. The residence was unable to account for the discrepancy.

Resident #2 prescribed Fentanyl 25mcg HR Patch- Apply one patch every 72 hours. However, on 9/26/23, there was only one Fentanyl patch remaining in the box. Review of the resident's September 2023 MAR and Controlled Drug Accountability (Receipt) Record/Disposition Form indicated the last Fentanyl patch was administered on 9/11/23. A new box was opened containing five Fentanyl patches; however, the Controlled Drug Accountability (Receipt) Record/Disposition Form indicates a "corrected count" of four Fentanyl patches in the box instead of five. The resident's September 2023 MAR and the Controlled Drug Form indicated, only three patches were administered after 9/11/23, on the following dates, 9/20/23, 9/23/23 and 9/26/23. The residence was unable to produce documentation to account for the one missing Fentanyl patch, between 9/11/23 and 9/20/23.

Plan of Correction ***Directed [redacted] 11/16/2023)***

2800.185a--- Storage and procedures
Through previous inspections and or violations Administrator and or designee have already completed initial whole

185a Storage procedures (continued)

house audits on Narcotic medications, these audits were completed in October. The administrator and or designee complete random audits to ensure Narcotics are signed out, the count is correct, and the medications are all accounted for. Administrator and or designee have held multiple educations for all direct care staff, and management staff on how to log new narcotics into the narc accountability sheet, how to subtract, and how to do an accurate narc shift count. This new audit will continue weekly beginning the week of 11/20/23 for one additional month and then three more months going forward, to be completed by administrator and or designee.

DIRECTED
Within 3 days or receipt of the accepted plan of correction: The administrator shall notify the residents and residents designated persons of any unaccounted medications cited in the violation and replace the medications at the cost of the home. 11/16/23 [redacted]

Directed Completion Date: *11/19/2023* Not Implemented ([redacted]-11/21/23)

187b Date/time of med admin

16. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #11 is prescribed the following medications.
** Allopurinol tablet, 100mg - take one tablet every day (9:00 a.m.).*
** Doxycycline hyclate tablet, 100mg- take one tablet twice daily (8:00 a.m. & 4:00 p.m.).*
** Finasteride tablet, 5mg – take one tablet one time daily (9:00 a.m.).*
** Pantoprazole tablet, 40mg delayed release – take one tablet twice daily (9:00 a.m. & 9:00 p.m.).*
** Metoprolol tartrate tab, 25mg – take ½ tablet (12.5mg) twice daily (9:00 a.m. & 9:00 p.m.).*
** Tamsulosin capsule, 0.4mg – take one capsule daily (9:00 a.m.).*
On 9/28/23, interviews indicated on 9/25/23, resident #11 was not administered the 9:00 a.m. medications; however, direct care staff person E signed off on resident #11's September 2023 MAR, as administering the prescribed medications to the resident, Interviews indicated direct care staff person E informed the resident [redacted] *at approximately 11:24 a.m., that* [redacted] *had put the residents morning medications in a med cup and left on the counter in the residents living unit. The resident took the medication at approximately 11:30 a.m.*

Plan of Correction ***Directed*** [redacted] ***- 11/16/2023)***

2800.187b--- Date and Time of Med Admin
Through previous inspections and or violations Administrator and or designee have provided whole education on charting and signing out on time in the month of October. Education was provided to all med techs, and or LPNS who pass medications. Administrator and or designee currently and will continue to run reports three to four times a day on medication compliance. This report tells us if a medication was late, not given etc. Running these reports will continue for the foreseeable future until issues are resolved. Additionally, administrator and or designee will provide the policy and procedures regarding medication administration to all med techs and or LPNS. Starting the week of 11/20/23 administrator and or designee will randomly pair up with a med tech and or LPN to watch a Med Pass to ensure charting, documentation, and the med pass is completed correctly and accurately. This will be completed weekly for four weeks, then move to monthly for three months.

187b Date/time of med admin (continued)

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall reconcile resident #11's MAR. 11/16/23 [redacted]

Directed Completion Date: 11/17/2023 Not Implemented [redacted]-11/21/23)

187d Follow prescriber's orders

17. Requirements

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

Description of Violation

On 9/28/23, interviews indicated on 9/25/23, resident #11 is prescribed the following medications identified as: Allopurinol tablet 100mg, to be administered at 8:00 a.m. and Doxycycline hyclate tablet, 100mg, Finasteride tablet, 5mg, Pantoprazole tablet, 40mg delayed release, Metoprolol tartrate tab, 25mg – ½ tablet (12.5mg), and Tamsulosin capsule, 0.4mg to be administered at 9:00 a.m. However, resident #11 was not administered the medication as prescribed, direct care staff person E placed in a med cup and put on the kitchenette counter in the resident's living unit, sometime between 9:30 a.m. and 11:25 a.m. for the resident to take upon return from appointment. The resident is not assessed to self-administer these medications. Interviews indicated the resident #11's [redacted] *confirmed the resident took the medication at approximately 11:30 a.m.*

Plan of Correction ***Directed*** [redacted] ***- 11/16/2023)***

2800.187d--- Follow Prescribers orders
Through previous violations and or inspections Administrator and or designee have provided whole house education to med techs and or LPNS on following doctors orders and how to properly read the EMAR. Administrator and or Designee do random spot checks where administrator and or designee will watch the Med Tech on Duty complete a med pass weekly. These random checks were started on 10/31/23, and will continue for an additional four weeks, then move to monthly for three months these will be completed by administrator and or designee. On the spot education will be provided if needed by administrator and or designee. If a medication error is completed, the resident, residents family and or POA, and the doctor will be notified. The reportable incident report will also be completed, all of this will be completed by the administrator and or management staff. The information regarding this medication error will be in the residents record, and also be filed in a facility binder. The Facility binder will be kept in the administrators office.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall notify resident #11, resident #11's designated person, and resident #11' prescriber of the medication error. Documentation of the notifications shall be kept. 11/16/23 [redacted]

Directed Completion Date: *11/17/2023* Not Implemented [redacted]-11/21/23)

191 Resident right to refuse

18. Requirements

2800.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

On 9/28/23, resident #11's record does not include any documentation that the resident was educated on the right to

191 Resident right to refuse (continued)

question or refuse medication, if the resident believes there may be a medication error.

Plan of Correction ***Directed [redacted] - 11/16/2023)***

2800.191--- Resident right to refuse
Administrator and or designee completed an initial audit of all residents on contracts. Facility held a contract signing day where all current residents signed a new Saber contract. The contract signing days were in October, and resident that has not signed a new contract has been re contacted in November. Weekly audits to be completed by administrator and or designee began 11/5/23 and will continue until all residents have a signed contract. However, In the contract there is verbiage that a resident has the right to refuse. Administrator and or designee held education in October to all med techs and or LPNS about the residents right to refuse, and resident rights as a whole.

DIRECETD
Within five calendar days of receipt of the accepted plan of correction: Teh administrator shall educate all staff persons involved with the admissions process on the requirements of Regulation 2800.191. Documentation of education shall be kept in accordance with Regulation 2800.65(l). 11/16/23 [redacted]

Directed Completion Date: *11/21/2023* Not Implemented [redacted]-11/21/23)

224a2 30 days prior to admission

19. Requirements

2800.
224.a.2. An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

Description of Violation

Resident #4, admitted [redacted]/202 initial assessment is not dated, therefore unable to determine if the initial assessment was completed 30 days prior to admission to the residence.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

2800.224.a.2--- 30 days prior to admission
Administrator and or designee have already completed whole house audits on current in house residents. Through this audit we were able to find which residents were out of compliance with an ASP or ADME. Since this audit was completed in October, this resident in particular number 4 has received a new updated ASP and ADME. Also; now there is a tracking system that shows what residents are due which month to ensure we stay on top of this.

Licensee's Proposed Overall Completion Date: 11/17/2023 Not Implemented [redacted]-11/21/23)

224a3 15 days after admission

20. Requirements

2800.
224.a.3. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days after admission if one of the following conditions applies:

Description of Violation

Resident #4, admitted [redacted]/202 assessment does not indicate the date the final assessment, therefore unable to determine if the final initial assessment was completed within 15 days after admission to the residence.

224a3 15 days after admission *(continued)*

Plan of Correction ***Accept [redacted] - 11/16/2023)***

2800.224a3--- 15 days after admission
Administrator and or designee have already completed whole house audits on current in house residents in September and October. Through this initial audit we were able to find which residents were out of compliance with an ASP or ADME. Since this audit was completed in October, this resident in particular number 4 has received a new updated ASP and ADME. Based off of this violation administrator and or designee have created a monthly spreadsheet that states in which month does each residents ADME and or ASP expire. Administrator and or Designee will complete biweekly audits to ensure all ADME (initial, and annual), ASPS (initial and annual), and Significant changes are completed appropriately.

Licensee's Proposed Overall Completion Date: 11/17/2023 Not Implemented - [redacted] 11/21/23

224c1 Initial SP-30 days prior/adm

21. Requirements

2800.
224.c.1. An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

Description of Violation

Resident #4, admitted [redacted]/22, preliminary support plan is not dated, therefore, unable to determine if the preliminary support plan was completed 30 days prior to admission to the residence.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

2800.224.c.1--- SP 30 days prior/admin
Administrator and or designee have already completed whole house audits on current in house residents in September and October. Through this initial audit we were able to find which residents were out of compliance with an ASP or ADME. Since this audit was completed in October, this resident in particular number 4 has received a new updated ASP and ADME. Based off of this violation administrator and or designee have created a monthly spreadsheet that states in which month does each residents ADME and or ASP expire. Administrator and or Designee will complete biweekly audits to ensure all ADME (initial, and annual), ASPS (initial and annual), and Significant changes are completed appropriately.

Licensee's Proposed Overall Completion Date: 11/17/2023 Not Implemented ([redacted]-11/21/23)

224c2 Initial SP-15 days after/adm

22. Requirements

2800.
224.c.2. A resident requiring services shall have a written preliminary support plan developed within 15 days after admission if one of the following conditions applies:

Description of Violation

Resident #4, admitted [redacted]/22, final support plan is not dated, therefore, unable to determine if the final support plan was completed within thirty days after the admission to the residence.

224c2 Initial SP-15 days after/adm *(continued)*

Plan of Correction ***Accept [redacted] - 11/16/2023)***

2800-224.c2--- Initial SP 15 days after/adm
Administrator and or designee have already completed whole house audits on current in house residents in September and October. Through this initial audit we were able to find which residents were out of compliance with an ASP or ADME. Since this audit was completed in October, this resident in particular number 4 has received a new updated ASP and ADME. Based off of this violation administrator and or designee have created a monthly spreadsheet that states in which month does each residents ADME and or ASP expire. Administrator and or Designee will complete biweekly audits starting week of 11/20/23 to ensure all ADME (initial, and annual), ASPS (initial and annual), and Significant changes are completed appropriately.

Licensee's Proposed Overall Completion Date: 11/17/2023 Not Implemented [redacted]-11/21/23)

224c8 Preliminary support plan - participants' signatures

23. Requirements

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

Description of Violation

Resident #4's preliminary support plan is not signed by the resident, nor does it indicate if the resident is unable to or refused to sign the document.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

2800.224c.8 Signatures
Administrator and or designee have already completed whole house audits on current in house residents on ASPS. Through this audit we were able to find which residents were out of compliance with an ASP or ADME. Since this audit was completed in October, this resident in particular number 4 has received a new updated ASP and ADME. Once the ASP is completed staff which include administrator and or management staff are instructed to immediately meet with the resident and discuss the findings, and have them sign the ASP if they so choose. If the resident chooses not to sign their contract staff will mark appropriately. Audits completed by the administrator and or designee will begin biweekly the week of 11/20/23 and will continue as needed.

Licensee's Proposed Overall Completion Date: 11/17/2023 Not Implemented [redacted]-11/21/23)